CHAUTAUQUA COUNTY SCHOOL DISTRICTS' MEDICAL HEALTH PLAN

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SUMMARY PLAN DESCRIPTION

This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of insurance. Municipal corporations participating in the municipal health benefit plan are subject to contingent assessment liability.

Adopted by the Chautauqua County School Districts' Medical Health Plan Cooperative Members on February 16, 2001
Updated 10/1/02 **and 7/1/10**
Form No. CCSDMHP

SUMMARY OF BENEFITS

INDEMNITY MEDICAL PLAN SUMMARY	
Annual Deductible Single Family	Depends on your District $50 or $100 or $200 or $250 or $400 or $500 per individual $100 or $200 or $400 or $500 or $800 or $1000 per family
Annual Out of Pocket Maximum	$400 per individual or $300 per individual for participants in Option 4 of the Prescription Drug Plan
Ambulatory Care (Diagnostic X-ray and Laboratory)	100% of Reasonable & Customary (*R&C*) *– Please see definition on page 5 of Section I*
Inpatient Hospital	100% of R&C for up to 365 days per confinement
Inpatient Mental Health; Chemical Dependence or Abuse	100% of R&C
Outpatient Mental Health;	80% of R&C coverage after deductible
Ambulance Services	100% of R&C coverage
Chiropractic Care	80% of R&C coverage after deductible
Outpatient Chemical Abuse or Dependence Treatment	100% of R&C
Inpatient Physician	100% of R&C coverage
Outpatient Physician	80% of R&C after deductible
Surgery Physician Charges Facility Charges	 100% of R&C coverage 100% of R&C coverage
Supplemental Accident	100% of R&C for the first $500 resulting from an accident
Annual OB/GYN & Maternity Care	100% of R&C coverage for laboratory and test charges for pap smear – see Section III Medical Plan for further details
Well Child Care/ Preventative Primary Care	100% of R&C coverage
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	80% of R&C after deductible
Preadmission Testing	100% of R&C coverage
Emergency Room	100% of R&C coverage
Home Care	100% of R&C coverage for up to 365 visits (4 hours equals 1 visit)
Second Surgical Opinion	100% of R&C coverage
Second Cancer Opinion	80% of R&C after deductible
Hospice Care	80% of R&C after deductible
Mammography Screening	100% of R&C coverage
Mastectomy	100% of R&C coverage
Breast Reconstruction after a Mastectomy	100% of R&C coverage
Infertility Treatment	100% of hospitalization, surgical care, laboratory tests, and FDA-approved drugs (subject to copay); 80% of medical care for the diagnosis of infertility
Diabetes Testing and Treatment	100% of R&C after deductible
Diagnostic Screening & Treatment of Prostatic Cancer	100% of R&C coverage
Bone Mineral Density Measurements, Testing, and Treatment	100% of R&C coverage for men & women meeting eligibility requirements
Diagnosis & Treatment of Eating Disorders	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment

Diagnosis & Treatment of Autism Spectrum Disorder	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment
PRESCRIPTION DRUG PLAN	
Prescription through Medical Plan	80% of R&C after deductible
Prescription Drug card Option 1 Option 2 Option 3 Option 4 Option 5 Option 6 Option 7 Option 8 Option 9 Option 10 Option 11 Options 12	 $1 copay $5 copay $5 copay for generics/$10 copay for brand drugs 20% coinsurance per prescription up to the first $100; then 100% coverage $7 copay $10 copay $5/$10 with $250 deductible $3/$10/$20 Copays $7/$15/$35 Copays $10/$20 Copays $10/$20/$40 Copays 20% Coinsurance per prescription up to the first $250, then 100% coverage

This is a brief summary of the benefits available. A complete description of your benefits, including any additional provision or limitations is contained in the body of this document.

SUMMARY OF BENEFITS		
POINT OF SERVICE MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maxiumu	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible -
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full ($10 Copay if performed in a physician's office)	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventative Care Adult Physical Well Child Care – to age 19	$10 Copay Covered in full	No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-authorized. Covered in full; limited to 50 days per year regardless of in/out of network.	Must be pre-authorized. 80% of Fee Schedule after deductible
Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services
Home Care Services	$10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	
Mammography Screening	Covered in full	
Mastectomy	Covered in full	80% of Fee Schedule after

		deductible
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible
Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – See Part III for eligibility requirement	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
PRESCRIPTION DRUG PLAN		
Prescription Drug Card	**Up to a 30 day Retail Supply**	
Option 5	$7 copay	
Option 6	$10 copay	
Option 7	$5/$10 with $250 deductible	
Option 8	$3/$10/$20 Copays	
Option 9	$7/$15/$35 Copays	
Option 10	$10/$20 Copays	
Option 11	$10/$20/$40 Copays	
Option 12	20% Coinsurance per prescription up to the first $250, then 100% coverage	
Option 13	$7/$15 copay	
Option 14	$5/$10/$25 copay	

** Member must select a Primary Care Physician (PCP) from the In-network Providers of the Medical Administrator. To receive the greatest benefit under the Point of Service Plan, it is required that members receive a referral from their PCP for all specialty care.*

***Out-of-Network benefits are paid by the Plan if a member forgets to get a referral from their PCP and/or receives care from a non-participating provider.*

This is a brief summary of the benefits available. Not all districts offer all benefits. Please check with your district for your benefit eligibility. A complete description of the benefits, including any additional provision or limitations. contained in the body of this document.

SUMMARY OF BENEFITS PREFERRED PROVIDER ORGANIZATION MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT - PPO*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maximum	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible -
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible -
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full	 80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventative Care Adult Physical Well Child Care – to age 19	 $10 Copay Covered in full	 No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay	80% of Fee Schedule after deductible
Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services
Home Care Services	365 Visits @ $10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-approved; Covered in full	Must be pre-approved; 80% of Fee Schedule after deductible
Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	Covers specialists' actual charges.
Mammography Screening	Covered in full	
Mastectomy	Covered in full	
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible

Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA approved drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – Where eligibility requirements are met.	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
PRESCRIPTION DRUG PLAN		
Prescription Drug Card	**Up to a 30 day Retail Supply**	
Option 5	$7 copay	
Option 6	$10 copay	
Option 7	$5/$10 with $250 deductible	
Option 8	$3/$10/$20 Copays	
Option 9	$7/$15/$35 Copays	
Option 10	$10/$20 Copays	
Option 11	$10/$20/$40 Copays	
Option 12	20% Coinsurance per prescription up to the first $250, then 100% coverage	
Option 13	$7/$15 copay	
Option 14	$5/$10/$25 copay	

***Out-of-Network benefits are paid by the Plan if a member receives care from a non-participating provider.*

This is a brief summary of the benefits available. Not all districts offer all benefits. Please check with your district for your benefit eligibility. A complete description of the benefits, including any additional provision or limitations. contained in the body of this document.

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SECTION I

INTRODUCTION

I. INTRODUCTION

The Chautauqua County School Districts' Medical Health Plan is an important component of the benefits provided to school district employees. The Medical Health Plan supports you as you address your own health care needs and those of your dependents. Under the terms of the Plan, you may choose what medical services you receive and who provides your health care. The Plan will only reimburse for Medically Necessary Covered Services as outlined in the remainder of this Summary Plan Description.

SECTION II

KEY TERMS

II. KEY TERMS

Following are certain words and phrases used in this document with the definition or explanation of the manner in which the term is used for the purposes of this Plan.

Ambulatory Surgical Center
A lawfully operated facility that meets all of these tests:
- it is established, equipped and operated mainly to perform surgical procedures on an outpatient basis;
- it is operated under the supervision of a staff of doctors and provides the full time services of at least one registered graduate nurse;
- it is licensed by the jurisdiction in which it is located, or is approved by the Plan Sponsor;
- it has at least two operating rooms and at least one post-anesthesia recovery room;
- it maintains medical records for each patient;
- it has a written transfer agreement with one or more hospitals;
- it does not provide its own place for patients to stay overnight; and
- it is not an establishment which:
  a) is operated by one or more doctors solely for their patients; or b) exists primarily for purpose of terminating pregnancies.

Birthing Center
A facility that is licensed by a state to provide prenatal, delivery, postpartum, newborn and gynecologic services to pregnant women.

Coordination of Benefits
A cost-sharing mechanism through which benefits covered by more than one medical plan are coordinated to allow maximum cost effectiveness and minimize multiple payments for a single service.

Copayment
A percentage of the provider's charge that you are responsible for after you meet your annual deductible. For most services included in your Major Medical coverage, your copayment is 20 percent.

Dependent
A covered person other than the covered member, including the following:
- Your legally married spouse, including same-sex spouses in legal out of state marriages
- Effective 7/01/2011 children under age 26 who regardless of marital status or financial dependence
- Until July 1, 2011, unmarried children age 19 or older until reaching 25 years of age, provided the child is a full-time student in an educational institution or dependent on you for support and maintenance*
- Until July 1, 2011, unmarried children age 19 or older who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental

retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who are chiefly dependent upon such member for support and maintenance. The Plan may ask you for proof of the handicap (if proof of the handicap is not produced within 31 days of request, participation in the Medical Plan will end).

* Financial dependency is generally proved by being able to claim a dependent on your federal tax return or by contributing more than 50% of the cost for your child's support and maintenance.

Emergency Illness
In accordance with New York State law, an emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or serious impairment to such person's bodily functions, or the serious dysfunction of any bodily organ or part of such person, or the serious disfigurement of such person.

Full-time Employee
An employee who customarily works a regularly scheduled work week, with a participating employer, as determined by the individual district.

Home Health Agency
An organization, or its distinct part, that meets all these tests:
- its primary purpose is providing skilled nursing and other services on a visiting basis in the covered person's home;
- it is licensed or approved under any state or local standards that apply;
- it is run under policies established by a professional staff that includes doctors and registered nurses;
- it is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending physician; and
- it does not, except incidentally, provide care or treatment of mental illness, chemical dependence or abuse, or care of a custodial nature.

Hospital
A short-term, acute, general hospital licensed by the state agency responsible for licensing such hospitals that meets all of these tests:
- its primary purpose is providing in patient facilities continuously supervised by one or more doctors where diagnostic and therapeutic services are provided for the diagnosis, treatment, and care of injured and sick persons;
- it provides day and night lodging which includes nursing service supervised by registered professional nurses;
- if located in New York State, it has in effect a hospitalization review plan applicable to all patients which meets the federal standards set forth in 42 U.S.C.A. § 1395x(k);
- it is organized into departments of medicine and major surgery;

- it has a requirements that every patient must be under the care of a physician or dentist;
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the ages, a place for drug addicts, or a place for convalescent, custodial, educational or rehabilitory care.

Hospital Confinement
Continuous hospital confinement means consecutive days of in-hospital service received as an inpatient where a room and board charge is made in connection with his confinement, the confinement results from a non-occupational injury requiring emergency care, or the confinement is required because of a surgical procedure. Successive periods of hospital confinements shall be considered a single confinement unless:
- the Medical Plan Supervisor receives satisfactory evidence of complete recovery from the first confinement, or
- in the case of an employee, the second confinement commenced after the employee had returned to active service for at least 2 weeks, or
- in the case of a non-employee, the second confinement commenced after the non-employee had engaged in normal activity for at least 2 weeks.

In determining whether there has been continuous confinement, confinement for an accident shall not be combined with another confinement for another illness.

Incurred Expense
An expense will be considered to be incurred at the time the service or the supply to which it relates is provided.

Injury and Illness
In this plan the word "injury" means an accidental bodily harm. The word "illness" means:
- sickness that impairs a covered person's normal function of mind and body;
- the pregnancy, childbirth and related medical conditions of a covered person;
- a covered child's functional defect caused by premature birth or congenital malformation; and
- a covered child's "well baby care" as discussed below;
- complications of pregnancy, which includes: acute nephritis or nephrosis; cardiac decompensation or missed abortion, or similar conditions as severe as these; a non-elective caesarean section; an ectopic pregnancy; and spontaneous termination when a live birth is not possible; and
- not included are: false labor; occasional spotting; doctor-prescribed rest; morning sickness; pre-eclampsia; similar conditions not medically distinct from a difficult pregnancy.

In-Network
In-network services are services rendered by providers participating in the Plan.

Medically Necessary Covered Services
Medically Necessary Covered Services are those health services covered by the Plan that are required to preserve and maintain your health or your dependents' health as determined by acceptable standards of medical practice. The fact that a health professional may prescribe, order, recommend or approve a service or item does not, in itself, make the service or item medically necessary.

Medicare
The programs established by Title 18 or Public Law 80-70 (Statute 291) as amended, entitled Health Insurance For the Aged Act, and which include Part A-Hospital Insurance Benefits for the Aged; Part B-Supplementary Insurance Benefits for the Aged; and the program established by Public Law 108-173, Part D, Medicare Prescription Drug Benefits.

Mental Health Care
Mental Health Care means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of the Plan, is directed predominantly at treatable behavioral manifestations of a condition that the Plan determines (a) is clinically significant behavioral or psychological syndrome, pattern, illness or disorder, and (b) substantially or materially impairs a person's ability to function in one or more major life activities, and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Nurse
A Registered Graduate Nurse, or a Practical Nurse who is either licensed under the laws of the state in which he or she resides or is registered by an organization operated with the approval of the medical profession and not related by blood or marriage to the covered individual.

Nursery Charges
Expenses incurred by a newborn for routine care administered by a hospital or physician while confined.

Physician
For the purposes of this document, a person who is a legally qualified physician or dentist, podiatrist, psychiatrist, chiropractor, or osteopath to the extent only that they render services within the scope of their licensed specialty to any person participating under this Plan.

Plan Administrators
The entity assigned by the Plan Sponsors to administer the Plan. Such administrator shall have the authority and responsibility for the establishment of the funding method, and shall establish operating policy consistent with the objectives of the Plan, and except for establishing rates of contribution, shall have the power to amend the Plan to meet the regulatory provisions of the Act under which the Plan is created, or to protect the interests of the Plan participants.

Plan Fiduciary
Any person, or organization, with respect to the Plan who, or which (as the context may require) exercises any discretionary authority or control respecting management or dispositions of any Plan assets; or exercises any discretionary authority or responsibility of the administration of the Plan. The named fiduciary, for this Plan, shall be the Plan Sponsor.

Plan Supervisor
Any person or organization elected by the Plan which (as the context may require), renders any consulting service to the Plan Sponsors in connection with the operation of the Plan including but not limited to, processing and payment of claims, and such other services as may be delegated to it by the Plan Sponsor in accordance with the definitions of benefits provided under

this Plan. The Plan Supervisor's responsibility will be governed by the Plan Document, and in no event shall the Plan Supervisor be vested with discretionary authority as to the manner in which benefits are to be disbursed, or the manner in which any investment assets of the Plan are managed. The Plan Administrator of this Plan shall be that person, or organization, so identified in the Plan Document.

Primary Care Physician
The doctor you have selected from the Provider Directory to manage your health care if you have selected the Point of Service (POS) Plan. Your Primary Care Physician will render or coordinate most of your care.

Out-of-Network
Services rendered by providers not participating in the Plan.

Reasonable and Customary (R&C)
The reasonable and customary charge is based on the prevailing charge for that service or medical supply in the geographic area where it is provided. This "area" means a county or such area as necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made. Covered plan expenses will be reimbursed at the 90th percentile of R&C data.

Schedule of Allowances
The Schedule of Allowances is the negotiated fees that in-network providers have agreed to accept as full payment for their services under the Point of Service (POS) Plan or the Preferred Provider Organization (PPO) Plan.

Semi-Private and Ward
When used in the context of defining the type of hospital accommodations used by a plan participant, shall mean only those types of hospital room accommodations which are other than one bed rooms, or accommodations.

Skilled Nursing Facility and Rehabilitation Center
A lawfully operated institution, or its distinct part, that meets all these tests:
- its primary purpose is providing lodging and skilled nursing care, day and night, for persons recovering from an injury or illness;
- it is supervised on a full time basis by a doctor or registered nurse;
- it admits patients only upon the advice of a doctor;
- it keeps clinical records on all patients;
- it has the services of a doctor available at all times under an established agreement;
- it has established methods and procedures to dispense and administer drugs and biologicals;
- it has a written transfer agreement with one or more hospitals;
- it is not, except incidentally, a place for rest, a place for the aged, a place for the treatment of mental illness, chemical dependency or abuse.

Surgical Procedure
- a cutting operation;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins.

Totally Disabled
Disability to the extent that the employee is unable to perform substantially the usual and customary duties of his occupation; with respect to the dependant coverages, (if provided under the Plan) disability to the extent that the dependant is unable to perform the usual and customary duties or activities of a person in good health and of the same age and sex.

Well Baby Care
Routine preventative health care that is not related to an accident or sickness but that consists of:

- the usual tests, exams and other services given to a child by a hospital within the first 7 days of the child's life, and

- the usual periodic physical exams of a child by a doctor during the first year of the child's life; this includes the immunizations, tests and laboratory services normally done with such exams, as well as a routine circumcision.

SECTION III

MEDICAL PLAN

III. MEDICAL PLAN

This Summary Plan Description outlines important provisions of the medical options available to the eligible employees of the school districts that participate in the Chautauqua County School District's Medical Health Plan (the "Plan").

For Catastrophic Events
The provision of medical insurance helps to protect you from the financial hardship which high medical expenses can cause.

Along With Comprehensive Care
A basic medical plan combined with a major medical plan provides for a broad spectrum of services ranging from coverage for physician office visits to prescription drug coverage to inpatient hospitalization coverage.

A. MEDICAL PLAN ELIGIBILITY

1. Employee Eligibility

All covered employees are eligible to participate in the medical plan subject to the terms and conditions of your individual districts. At the time of enrollment, you may also elect to cover your eligible dependents.

In addition to your biological children, any stepchildren, foster children, legally adopted children, or children placed with you for adoption may also be covered if they meet the above requirements.

Effective July 1, 2011, under Federal Law, coverage for adult children, regardless of marital status, is available through age twenty-six, so long as they are not insured by or eligible for coverage under any employee health benefit plan as an employee or plan participant. The parent of the adult child will need to be enrolled in the appropriate tier of coverage prior to or at the date of enrollment of the adult child. The covered individual is responsible for 100% of the premium under the single contract and may not eligible for COBRA or New York State continuation coverage after reaching age twenty-six.

Under New York Law, coverage for unmarried children residing, living, or working in New York State or the service area for the Plan is available through age twenty-nine regardless of the child's financial dependence, so long as they are not insured by or eligible for coverage under any employee health benefit plan as an employee or plan participant. Contact your individual school district to obtain this coverage, which is provided under a single contract. The covered individual is responsible for 100% of the premium under the single contract and after exhausting the benefits (reaching age twenty-nine), is not eligible for COBRA or New York State continuation coverage.

Under a Qualified Medical Child Support Order (QMCSO), the requirements of proof of dependency will be waived. If a medical child support order is received, the Plan Administrator will determine whether the order is qualified and will notify you.

2. Retiree Eligibility

Retirees are eligible to continue coverage under the Plan, provided the individual school districts permit retirees to continue coverage.

- If a retiree elects to continue coverage under the Plan, the retiree thereafter may not receive any greater coverage than the coverage selected at the time of this election to continue coverage.

- A retiree who elects to continue coverage subsequently may elect at any time to reduce or cease their coverage under the Plan. An election to reduce or cease coverage will be irrevocable and the coverage may never be restored, except:

- a retiree will be permitted to change their coverage status (single to family) if the retiree's dependent(s) experience a Qualifying Event and the retiree has been continuously covered as a single contract under the Plan and the request to change coverage is made within 30 days of the event. A Qualifying Event will be considered an event due to:
    a. Loss of other group coverage because of loss of employment of the spouse (laid off, terminated, reduction of hours or retirement)
    b. Marriage
    c. Death
    d. Divorce
    e. Loss of coverage due to a dependent child reaching the limiting age of other group coverage that is lower than the Plan's limiting age of 25.

- Retirees may never re-enroll in the Plan if they previously declined coverage at retirement or at a later date with the following exception:

    a. If the retiree declines coverage at retirement because their spouse is a covered active employee of a district covered by the Plan, they will be permitted to re-enroll under their retiring district upon retirement of their spouse, provided their district permits this change.

B. ENROLLMENT

Coverage for you and your dependents will become effective according to each district's requirements and upon submission of your enrollment form. Each eligible employee may elect to obtain coverage for his or her eligible dependents by including the eligible dependent's information on the enrollment form, provided the application for coverage is submitted within 31 days of the eligibility date. The effective date of coverage for an employee's eligible dependents will be the same date that the employee's coverage becomes effective. Once you are enrolled you will receive a medical plan identification card, and a

prescription drug card unless you receive drugs under the Major Medical Plan option. NOTE: By enrolling in a medical plan you are required to be covered under one of the options described in the Prescription Plan (see Section IV).

1. Coverage Levels

You may select from two levels of coverage:

- Employee-only
- Family (you plus any eligible family members)

2. If You Do Not Enroll Within 31 Days Of Eligibility

Coverage under the medical plan is not automatic. You must submit an enrollment form within 31 days of first becoming eligible. Your individual school district will provide you with materials to aid you in your enrollment decision.

If you fail to enroll within the 31 day period you will not be eligible for coverage until the next July 1. Therefore, it is important that you return the completed enrollment form on time. Prior to the July 1 effective date, during *open enrollment* (March 1 – March 31), you will be given the opportunity to make benefit elections or changes.

3. Open Enrollment And Mid-Year Coverage Changes

Open enrollment is conducted annually between March 1 and March 31 for coverage starting July 1 and continuing for 12 months through the following June 30. Once a year, you are given the opportunity to make coverage elections or changes. The new coverage will take effect as of July 1st following the enrollment period. If you currently have coverage and do nothing, you will retain the same coverage option that is in effect on June 30.

If you are not currently covered, between March 1st and March 31st you may elect coverage or if you are currently covered you may elect to change your coverage level during that same period. For example, if you initially had elected single coverage, despite being married, you may now elect dependent coverage.

Or on the other hand, if you had initially declined coverage entirely, you may enroll during this period. If you do not change coverage during the *open enrollment*, a change will not be allowed until the next *open enrollment* unless you experience a family status change.

Once you complete your enrollment form and coverage for you and your dependents begins, effective July 1, you may not revoke your election or make any changes in your coverage level during that year unless you have a *qualified change in family status* (see below). If you have a family status change, the Plan Administrator will determine if it is a qualified change.

4. Adding Or Dropping Family Member Coverage

The following family status changes allow you to change coverage during a Plan year:

- Your marriage or divorce
- Death of your spouse or dependent
- Birth, adoption, or marriage of a dependent
- Termination or commencement of your spouse's employment
- Change in your or your spouse's employment status (from part-time to full-time or vice-versa)
- Any unpaid leave of absence taken by you or your spouse
- You lose or gain significant health insurance coverage through your spouse's employer

New dependents acquired through "life events" (marriage, adoption, foster care, etc.) must be enrolled through the submission of an enrollment form within 30 days of the event or must wait until the next open enrollment to become covered dependents. In cases involving a newborn, if the newborn is not enrolled within 30 days of birth, the newborn will be enrolled and coverage will be effective as of the next premium due date following the request for enrollment.

If the school district receives a court-ordered Qualified Medical Child Support Order requiring that you provide health coverage for a child, your child may be enrolled even if it is not within 30 days of a family status change.

Under New York State law, a young adult who qualifies for coverage may enroll at anytime during a twelve (12) month open enrollment period ending on 6/30/2011. Following this twelve (12) month period, a young adult may elect to receive coverage within sixty (60) days of meeting the eligibility requirements outlined above. A young adult may also enroll during the annual thirty (30) day open enrollment period. Coverage is effective within thirty (30) days of the Plan's receipt of notice of the election to enroll and payment of the first premium.

Any change in coverage as a result of a family status change as mentioned above must be consistent with the change in family status.

5. Special Enrollment Periods

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan. You must request enrollment within 30 days after your or your dependents' coverage ends. If you have a new dependent as a result of marriage, adoption or placement for adoption, you may be able to enroll yourself and your dependents. You must request enrollment within 30 days after the marriage, adoption or placement for adoption. If you request coverage for a newborn dependent more than 30 days following birth, the newborn will be enrolled and coverage will be effective as of the next premium due date.

Special Enrollment Rights under SCHIP

If you have declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or the State Children's Health Insurance Program (SCHIP), there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if you have declined enrollment in the Plan for yourself or your dependents (including a spouse), and later become eligible for state assistance through a Medicaid or State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance, if the State makes such assistance available. If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

6. Prior Authorization

All inpatient services, including inpatient mental health services, require pre-authorization to be eligible for coverage by the Plan.

C. PLAN CONTRIBUTIONS

Both you and the school district contribute toward the cost of your coverage. The amount of cost sharing will depend on the plan and coverage level you select. You may obtain rate information from your respective school district.

D. SUMMARY OF MEDICAL BENEFITS – TRADITIONAL/INDEMNITY PLAN

1. Description of Traditional/Indemnity Benefits

Your traditional/indemnity medical plan benefits are separated into two separate categories: Basic Services as defined in Section D.2. below and Major Medical Services.

NOTE: Prescription drug coverage is detailed in Section IV of this Summary Plan Description.

The Plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Medical Plan Supervisor regularly reviews the reasonable and customary charge schedule. To confirm whether your provider's charges are within the reasonable and customary limit, obtain a Predetermination of Benefits. You can obtain a Predetermination of Benefits through a written request to the Medical Plan Supervisor.

All descriptions of covered services mentioned throughout this Summary Plan Description refer to the reasonable and customary charges for such services.

2. Basic Services Benefits – Key Features & Covered Benefits

a. INPATIENT HOSPITAL CARE

The following services are covered services under the Inpatient Hospital benefit:

- Bed, board and general nursing services in a semi-private room, up to 365 days per confinement. A semi-private room is a room that the hospital considers to be semi-private. If you occupy a private room in a participating hospital, the Plan will cover up to the average charge for a semi-private room.
- Bed, board and general nursing services in a private room, if such room is deemed to be medically necessary.
- Use of operating, recovery and cystoscopic rooms and equipment.
- Use of intensive care or special care units and equipment.
- The administration and use of drugs, medications, sera, vaccines, intravenous preparations to the extent these items are commercially available and readily obtainable by the hospital.
- Dressings and plaster casts.
- Professional and equipment services in connection with the services listed below under the condition that the services are provided by a hospital employee and the charge for the services is payable to the hospital:
  - Oxygen
  - Physiotherapy
  - Laboratory and pathological examinations
  - Radiation therapy
  - Chemotherapy
- Use of equipment and supplies in connection with the services listed below. Physician charges or professional fees charges for the following services are not covered under the Basic Benefits portion of the medical plan, but can be submitted to the Major Medical portion for reimbursement:
  - Anesthesia
  - Electrocardiograms
  - Electroencephalograms
  - X-ray examinations
- Blood products, except when participation in a volunteer blood replacement program is available to you.
- Any additional medical services and supplies which are customarily provided by hospitals.
- Bed, board, general nursing services, the use of equipment and supplies in connection with a hospital stay for such period as is determined by the attending physician in consultation with the patient to be medically appropriate after such covered person has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Plan. Coverage for the length of stay in the hospital may not be restricted in a manner which is inconsistent with the coverage provided to the portion of the stay that preceded the lymph node dissection, lumpectomy or mastectomy. The Plan covers breast prosthetics and other complications of a mastectomy including lymphedemas.

b. EMERGENCY CARE

The Plan pays 100% of covered charges for outpatient and emergency room services with no deductible for services.

c. CARE IN CONNECTION WITH A SURGERY

The Plan pays 100% of covered charges for facility and medical equipment services with no deductible for outpatient surgical procedures.

d. PRE-ADMISSION TESTING

The Plan will pay 100% of covered charges with no deductible for tests ordered by a physician which are given to you before your admission to the hospital as a registered bed patient for surgery provided the following conditions are met:

- They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- You have made a reservation for the hospital bed and for the operating room before the tests are given;
- You are physically present at the hospital when the tests are given;
- Surgery actually takes place within 7 days after the tests were given.

e. HOME CARE

The Plan will pay 100% of covered charges for care received in your home by licensed or certified Home Care agencies (as determined by New York State Public Health Law) under the following conditions:

- If you did not receive Home Care visits, you would have to be hospitalized in a hospital or cared for in a skilled nursing facility.
- A plan for your Home Care is established and approved in writing by a physician.

The following services are considered covered expenses under the Home Care benefit:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical, occupational or speech therapy if the Home Care Agency or hospital provides these services.
- Medical supplies, drugs and medications prescribed by a doctor, but only if these items are covered if you are confined in a hospital or skilled nursing facility.
- Laboratory services provided by or on behalf of the Home Care Agency or hospital.

- Up to 365 visits in each calendar year. Each visit by a member of a Home Care team is counted as one Home Care visit. Four hours of home health aide service is counted as one Home Care visit.

f. AMBULANCE

Medically necessary transportation in an ambulance is covered at 100%.

Prehospital emergency medical services for the treatment of an Emergency Illness (as defined in Section II above) when such services are provided by a certified ambulance service.

"Prehospital emergency medical services" means the prompt evaluation and treatment of an Emergency Illness and/or non-airborne transportation to a hospital; provided however, where the patient utilizes non-air-borne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

g. INPATIENT MENTAL HEALTH CARE

The Plan pays 100% of covered charges for Active Treatment. "Active Treatment" is defined as treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the New York State Commissioner of Mental Health. Active Treatment must be provided in a hospital defined in Section 1.03(10) of the New York Mental Hygiene Law. Partial hospitalization is also covered, however, two partial hospitalizations days are equal to one covered inpatient day.

"Biologically Based Mental Illness" is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

"Children with Serious Emotional Disturbances" is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of

causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

h. INPATIENT ALCOHOL AND SUBSTANCE ABUSE

The Plan pays 100% of covered charges for inpatient detoxification.

3. Major Medical Benefits-Key Features

a. DEDUCTIBLE

Each calendar year, before the Major Medical portion of the Plan pays benefits, you must satisfy a deductible. Depending on your school district, a medical plan option with one of three deductible amounts will be offered:

- $ 50 individual / $100 family
- $100 individual / $200 family
- $200 individual / $400 family
- $250 individual / $500 family
- $400 individual / $800 family
- $500 individual / $1,000 family

Most expenses under the Major Medical portion of the Plan are subject to the deductible, however, please review the specific coverage to determine if the deductible applies.

The medical plan option you are offered by the school district *may* include a prescription drug card plan. Some prescription drug copayment options can be submitted to the Medical Plan Supervisor for coverage under the Major Medical benefit (prescription drug plan coinsurance amounts can not be submitted to the medical plan for reimbursement). If your medical plan does not include a separate prescription drug card plan, you still have coverage for prescription drugs through the Major Medical portion of your plan (covered at 80% and subject to your annual deductible).

b. HOW THE FAMILY DEDUCTIBLE WORKS

The family deductible is designed to limit a family's annual outlay for covered expenses before the Plan begins to pay benefits. Each family member's (including a newborn's) covered expenses up to his or her per person deductible count toward the family deductible. Once this family deductible is met, the Plan will begin to pay benefits for all family members, including those who have not yet incurred expenses. The Plan will also begin to pay applicable benefits for any covered family member who meets the individual deductible, even if the total family deductible is not met.

The covered expenses incurred in October, November, and December of the prior year that apply to that year's deductible, will be applied to the current year's deductible.

If two or more covered persons from the same family are injured in the same accident, only one deductible will be applied each year against the expenses incurred as a result of that accident.

c. 80% REIMBURSEMENT

After you have met your deductible (see below) the Plan reimburses 80% of the first $2,000 of covered Major Medical expenses. You pay the remaining 20% of covered expenses - your coinsurance - until you have met your annual out-of-pocket limit of $400 ($2,000 x 20%) after which the Plan will pay 100% of expenses for the remainder of the calendar year.

d. OUT-OF-POCKET LIMIT

Except as provided below, this is a cap on the amount of unreimbursed covered medical expenses you will have to pay in any one year. Once you reach your out-of-pocket limit, the Plan will pay 100% of your remaining covered expenses for that year.

Most unreimbursed covered expenses for both you and your covered family members count toward your out-of-pocket limit. Unreimbursed covered expenses generally include co-payment, deductible and coinsurance amounts, but do not include amounts your physician or health care provider may charge above the Reasonable and Customary charge or amounts exceeding the Plan's Schedule of Allowances, because those amounts are not covered expenses under the Plan. Prescription drug expenses reimbursed through a prescription drug card plan at the 20% coinsurance option (Option #4) do not apply towards your out-of-pocket limit.

In any calendar year, the Plan limits each participant's out-of-pocket expenses (excluding your deductible) to $400 ($300 for employees enrolled in the 20% coinsurance [Option #4] under the prescription drug plan) per participant.

e. MEETING YOUR OUT-OF-POCKET LIMIT

As an example, to meet the individual out-of-pocket limit of $400 if your individual deductible is $100, you must incur a total of $2,100 in covered medical expenses. Of this $2,100 you will pay $100 to meet your deductible and then 20% of each remaining covered expense until the total amount you have paid equals $400. Thus, in this example the total payment that you would be responsible for is equal to $500 ($100 deductible + $400 out-of-pocket limit).

At that point, the Plan begins paying 100% of covered expenses rather than 80%, up to any lifetime maximum or other Plan limitation.

f. ADDITIONAL BENEFITS – TRADITIONAL/INDEMNITY PLAN

Additional benefits include, but may not be limited to the following **(**subject to deductible, coinsurance, and out-of-pocket limit, unless otherwise noted):

(1) Allergy Treatment and Testing

The plan pays 100% with no deductible for allergy testing. Ongoing treatment of allergies will be covered at 80%, subject to the annual deductible.

(2) Second Cancer Opinion

The plan pays 80% of covered charges, after the deductible is met, for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer. A second cancer opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer. The cost shall be the same for a plan participant with a written referral to an out-of-network appropriate specialist as it is for the plan participant seen by an in-network appropriate specialist. However, without a referral, the plan participant will be responsible for any additional coinsurance payments.

(3) Chiropractic Care

The plan pays 80% of covered charges, after the deductible is met, for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

(4) Diabetes

The plan pays 100% of covered charges, after the deductible is met, for the following diabetes equipment and supplies when medically necessary: blood glucose monitors and blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar.

The plan pays 80% of covered charges, after the deductible is met, for diabetes self-management education when medically necessary. Education provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage also includes home visits when medically necessary.

(5) Diagnostic X-ray and Laboratory Coverage

The plan pays 100% of coverage charges, without a deductible, for each laboratory examination and x-ray examination performed in connection with the diagnosis of an injury or illness.

(6) Hospital Expenses In Excess Of Basic Benefit Coverage

The Plan pays 80% of covered charges, after the deductible is met, in excess of Basic Benefit coverage for medically necessary services, including outpatient clinic and non-emergency services.

(7) Outpatient Mental Health Treatment

The Plan pays 80% of Medically Necessary Covered Services, after the deductible is met, for outpatient mental health care. Coverage is only available to participants who receive outpatient mental health care from a facility that has an operating certificate issued by the New York State Commissioner of Mental Health, a psychiatrist, a psychologist, a licensed clinical social worker, a professional corporation, or a university faculty practice plan.

Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for in-network or out-of-network coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

"Biologically Based Mental Illness" is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

"Children with Serious Emotional Disturbances" is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

(8) Outpatient Chemical Abuse or Dependence Treatment

The Plan pays 100% of Medically Necessary Covered Services for the diagnosis and treatment of chemical dependence in any calendar year; Family therapy benefits are available to any family member who is a plan participant even if the alcohol or substance abuser is not covered under this Plan. Such coverage is limited to facilities in New York State which are certified by the office of alcoholism and substance abuse services as outpatient clinics, as medically

supervised ambulatory substance abuse programs and, in other states, to those which are accredited by the joint commission on accreditation of hospitals as alcoholism or chemical dependence substance abuse treatment programs.

(9) Physician Fees

The Plan pays 100% of covered charges, not subject to deductible, for physicians during an inpatient stay (up to one visit per physician per day). The Plan pays 80% of covered charges, after the deductible, for emergency room, outpatient hospital, and office visit services provided by a physician, licensed physician's assistant or nurse practitioner.

(10) Physician Surgical Fees

The plan pays 100% of covered charges for surgical services provided by a physician, second surgical opinions, and anesthesia services. These services are not subject to the annual deductible. The Plan will cover assistant surgeon fees, at 100% with no deductible, up to a maximum of 25% of the primary surgeon's covered expenses.

(i) Breast Reconstruction After a Mastectomy

The Plan pays 100% of covered charges for breast reconstruction after a mastectomy including all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance.

(ii) Oral surgery

Surgical services for oral surgery are covered at 80% and are subject to the annual deductible.

(11) Supplemental Accident Coverage

The Plan will cover at 100% for the first $500 for the covered charges resulting from an accident. The charges must be incurred within 90 days of the accident to be considered for coverage.

(12) Routine Mammogram and Pap Smear

The plan will cover at 100%:

- an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. The screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear;
- upon the recommendation of a physician, a mammogram for a covered person, regardless of age, who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer; a single baseline mammogram for covered persons aged thirty-five through thirty-nine; and an annual mammogram for covered persons aged forty and older.

These benefits are available as an outpatient or in a physician's office.

(13) Well-Child Care

The plan will cover at 100% the following services rendered to a covered dependent from the date of birth through the attainment of nineteen years of age:

- an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians;
- at each visit, a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests;
- necessary immunizations for diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b and such other immunizations as are required under guidelines published by the Advisory Committee on Immunization Practices;
- Newborn hearing screening services.

Routine immunizations in connection with a well-child visit are covered at 100% with no deductible.

(14) Other Medical Services

The Plan pays 80% of covered charges for the following health care services when medically necessary:

- Blood (including transfusion and the cost of whole blood and blood components)
- Cardiac rehabilitation
- Chemotherapy
- Dialysis
- Durable medical equipment (except for diabetic and ostomy supplies which are covered at 100%) – when accompanied by a letter of medical necessity from the attending physician
- Hospice
- Physical therapy
- Private duty nursing (up to four hours per day)
- Radiation therapy
- Respiratory therapy
- Occupational therapy
- Speech therapy

(15) Standard diagnostic screening for prostate cancer.

The Plan will cover 100% of covered charges for diagnostic screening for prostate cancer when prescribed by a licensed practitioner, as follows:

(a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and

(b) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

(16) Diagnosis and Treatment of Infertility.

Under the Plan, infertility means the inability to conceive after twelve (12) consecutive months of frequent, contraceptive free unprotected intercourse with the intent to conceive. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years. Recurrent pregnancy loss is a disease distinct from infertility, defined by two or more failed pregnancies.

Infertility services means medical or surgical procedures which are medically necessary to diagnose or correct a malformation, disease, or dysfunction resulting in infertility, and diagnostic tests and procedures that are necessary to determine infertility, including but not limited to, hysterosalpinogram, hysteroscopy, endometrial biopsy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests, and ultrasound.

To be eligible for infertility services, the participant must: 1) be at least twenty-one (21) years of age and no older than forty-four (44) years of age except for the diagnosis and/or treatment for a correctable medical conditions which results in infertility, 2) have a treatment plan submitted in advance to the Plan by a physician who meets the applicable training, experience, and other standards for the diagnosis and treatment of infertility as set by New York State, 3) have a treatment plan that is in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetrics and Gynecology; and 4) receive preauthorization from the Plan.

The Plan pays 100% of hospitalization and surgical care, laboratory tests, and FDA-approved drugs (after applicable prescription copay) and 80% of medical care for the diagnosis of infertility. However, the Plan does not cover any of the following: 1) reversal of elective sterilization, 2) cloning or any services incident to cloning, 3) experimental infertility procedures, 4) sex change procedures, and 5) all costs associated with in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and any drugs, self-injectable or otherwise, used in conjunction with any of the above procedures.

(17) Bone Mineral Density Measurements and Testing.

The Plan will cover at 100% bone mineral density measurements and testing for both men and women who meet eligibility criteria established by Medicare or the National Institutes of Health for the detection of osteoporosis as follows:

(a) Bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal Medicare program as well

as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(b) For purposes of this subsection, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage, consistent with the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall, at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with a lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Coverage is subject to annual benefit limits under the Plan. FDA-approved drugs and devices for bone density are also covered under the Plan, subject to all deductibles and co-payments for prescription drugs or durable medical equipment.

(18) Preventive Colorectal Cancer Screening Tests.

The Plan covers at 100% the following preventive colorectal cancer screening tests:

- Fecal Occult Blood Testing (FOBT).
- Sigmoidoscopy.
- Colonoscopy.

The preventive coverage for the above tests is payable under the Plan in accordance with American Medical Association guidelines.

4. Pregnancy And Maternity

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York

State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Home care services covered under the maternity benefit are not subject to deductibles, coinsurance or co-payments. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care.

5. Skilled Nursing Facility

Care provided through a skilled nursing facility will be covered at 80% subject to the annual deductible for participating facilities and 80% of reasonable and customary charges for a non-participating facility, subject to the annual deductible for up to 50 days per calendar year. Custodial care provided while in a skilled nursing facility is not covered; the care must be in conjunction with healing, rehabilitative services to be covered.

E. SUMMARY OF MEDICAL BENEFITS - POINT OF SERVICE PLAN (POS)

1. Description of Point of Service Benefit

The Medical Plan Supervisor has contracted with selected healthcare providers to render quality medical care at agreed fees. There are financial incentives to the participant and the Plan when these in-network providers are utilized. A list of in-network providers is provided separately from this SPD and is available at your School Business Office or online at the Plan's website, www.mybenesite.com\ccsd.

For example, when in-network providers are utilized, the plan pays for office visits at 100% with a $10 copayment. Payment for an out-of-network provider will be paid at 80% of the Schedule of Allowances subject to the annual deductible.

With the exception of emergency treatment due to an accident or life threatening illness, you must get a referral from an in-network primary care physician for your expenses to be paid at the in-network benefit level; otherwise they will be treated as out-of-network. Additionally, the out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers.

2. Out-of-Network Benefits are subject to Deductible and Co-insurance

a. Deductible

Each calendar year, before the Plan pays out-of-network benefits, you must satisfy an annual deductible: $250 individual / $500 family.

b. How the Family Deductible Works

The family deductible is designed to limit a family's annual outlay for covered expenses before the Plan begins to pay benefits. Each family member's (including a newborn's) covered expenses up to his or her per person deductible count toward the family deductible. Once this family deductible is met, the Plan will begin to pay benefits for all family members, including those who have not yet incurred expenses. The Plan will also pay applicable benefits for any covered family member who meets the individual deductible, even if the total family deductible has not yet been met.

If two or more covered persons from the same family are injured in the same accident, only one deductible will be applied each year against the expenses incurred as a result of that accident.

c. 80% Reimbursement

After you have met your deductible the Plan reimburses 80% of most out-of-network expenses. There are some specific exceptions to this rule that are described under specific benefit categories.

d. Out-of-Pocket Limit

Except as provided below, this is a cap on the amount of unreimbursed covered medical expenses you will have to pay in any one year: Once you reach your out-of-pocket limit, the Plan will pay 100% of the Schedule of Allowances for that year.

Most unreimbursed covered expenses for both you and your covered family members count toward your out-of-pocket limit. Unreimbursed covered expenses include deductible and coinsurance amounts-but do not include amounts your physician or health care provider may charge above the Schedule of Allowances or amounts exceeding Plan limits. Prescription drug copayments do not apply to meeting the limit.

In any calendar year, the Plan limits each participant's out-of-pocket expenses to $2,000 per participant or $4,000 per family. As an example, to meet the individual out-of-pocket limit of $2,000, you generally must incur a total of $10,000 in covered medical expenses. Of this $10,000 you will pay $250 to meet your deductible and then 20% of each remaining covered expense until the total amount you have paid equals $2,000. Thus, in this example the total payment that you would be responsible for is equal to $2,000 ($250 deductible + $1,750 out-of-pocket limit). Once the

family out-of-pocket limit is reached, all benefits (except for the limitations indicated above) will be paid at 100% for all family members including those who have not yet incurred any expenses.

3. Covered Benefits – POS Plan

a. PHYSICIAN OFFICE VISITS

In-network, after a $10 copayment, the Plan pays 100% of covered charges for office visit services provided by a physician, licensed physician's assistant or nurse practitioner. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

b. INPATIENT HOSPITAL CARE

In-network, the Plan pays 100% of covered charges. Out-of network, the Plan pays 80% of the Scheduled of Allowances after the deductible for these services.

The following services are covered services under the Inpatient Hospital benefit:

- Bed, board and general nursing services in a semi-private room, up to 365 days per confinement. A semi-private room is a room that the hospital considers to be semi-private. If you occupy a private room in a participating hospital, the Plan will cover up to the average charge for a semi-private room.
- Bed, board and general nursing services in a private room, if such room is deemed to be medically necessary.
- Use of operating, recovery and cystoscopic rooms and equipment.
- Use of intensive care or special care units and equipment.
- The administration and use of drugs, medications, sera, vaccines, intravenous preparations to the extent these items are commercially available and readily obtainable by the hospital.
- Dressings and plaster casts.
- Professional and equipment services in connection with the services listed below under the condition that the services are provided by a hospital employee and the charge for the services is payable to the hospital:

  - Oxygen
  - Physiotherapy
  - Laboratory and pathological examinations
  - Radiation therapy
  - Chemotherapy

- Use of equipment and supplies in connection with the services listed below. Physician charges or professional fees charged for the following services are not covered under the Basic Benefits portion of the medical plan, but can be submitted to the Major Medical portion for reimbursement:

- Anesthesia
- Electrocardiograms
- Electroencephalograms
- X-ray examinations

- Blood products, except when participation in a volunteer blood replacement program is available to you.
- Any additional medical services and supplies which are customarily provided by hospitals.
- Bed, board, general nursing services, the use of equipment and supplies in connection with a hospital stay for such period as is determined by the attending physician in consultation with the patient to be medically appropriate after such covered person has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Plan. Coverage for the length of stay in the hospital may not be restricted in a manner which is inconsistent with the coverage provided to the portion of the stay that preceded the lymph node dissection, lumpectomy or mastectomy. The Plan covers breast prosthetics and other complications of a mastectomy including lymphedemas.

c. EMERGENCY CARE

After a $50 copayment, the Plan pays for 100% of covered charges for an Emergency Illness as defined below. The copayment is waived if you are admitted to the hospital. An additional $50 copayment is required for non-emergency use of the emergency room. Emergency services are considered in-network even if a member accesses an out-of-network hospital.

An Emergency Illness is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (ii) serious impairment to such person's bodily functions, (iii) the serious dysfunction of any bodily organ or part of such person, or (iv) the serious disfigurement of such person.

d. CARE IN CONNECTION WITH A SURGERY

In-network, the Plan pays for 100% of covered charges for facility and medical equipment services with no deductible for outpatient surgical procedures. Out-of-network the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

e. PRE-ADMISSION TESTING

In-network, the Plan will pay 100% of covered charges with no deductible. Out-of-network, the Plan will pay 80% of the Schedule of Allowances after payment of the deductible. The Plan covers tests ordered by a physician which are given to you before your admission to the hospital as a registered bed patient for surgery provided the following conditions are met:

- They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- You have made a reservation for the hospital bed and for the operating room before the tests are given;
- You are physically present at the hospital when the tests are given;
- Surgery actually takes place within 7 days after the tests were given.

f. HOME CARE

In-network, after a $10 copayment the Plan pays 100% of covered charges. Out-of network, the Plan will pay 80% of the Schedule of Allowances after payment of the deductible. Covered charges include services for care received in your home by licensed or certified Home Care agencies (as determined by New York State Public Health Law) under the following conditions:

- If you did not receive Home Care visits, you would have to be hospitalized in a hospital or cared for in a skilled nursing facility.
- A plan for your Home Care is established and approved in writing by a physician.

The following services are considered covered expenses under the Home Care benefit:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical, occupational or speech therapy if the Home Care Agency or hospital provides these services.
- Medical supplies, drugs and medications prescribed by a doctor, but only if these items are covered if you are confined in a hospital or skilled nursing facility.
- Laboratory services provided by or on behalf of the Home Care Agency or hospital;
- Up to 365 visits in each calendar year. Each visit by a member of a Home Care team is counted as one Home Care visit. Four hours of home health aide service is counted as one Home Care visit.

g. AMBULANCE

Medically Necessary transportation in an ambulance is covered at 100% after a $50 copayment. All Medically Necessary transportation in an ambulance is considered to be an in-network benefit.

The Plan covers prehospital emergency medical services at the Emergency Care benefit level (see Subsection c. above) when such services are provided by a certified ambulance service.

"Prehospital emergency medical services" means the prompt evaluation and treatment of an Emergency Illness (as defined in Subsection c. above) and/or non-air-borne transportation to a hospital; provided however, where the patient utilizes non-air-borne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

h. INPATIENT MENTAL HEALTH

In-network, the Plan pays 100% of covered charges for Active Treatment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for Active Treatment. Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for coverage. The Plan's mental health benefit manager must also coordinate the care that is provided. “Active Treatment” is defined as treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the New York State Commissioner of Mental Health. Active Treatment must be provided in a hospital defined in Section 1.03(10) of the New York Mental Hygiene Law. Partial hospitalization is also covered, however, two partial hospitalizations days are equal to one covered inpatient day.

“Biologically Based Mental Illness” is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

“Children with Serious Emotional Disturbances” is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive

behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

i. INPATIENT ALCOHOL AND SUBSTANCE ABUSE

In-network, the Plan pays 100% of covered charges for inpatient detoxification. Out-of-network, the Plan pays 80% of the Schedule of Allowances for inpatient detoxification after the deductible.

j. LABORATORY

In-network, the Plan pays 100% of covered charges, without a deductible, for each laboratory examination performed in connection with the diagnosis of an injury or illness at a participating facility. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible, up to a maximum of $100 per participant per year.

k. PHYSICALS

In-network, after a $10 copayment, the Plan pays 100% of covered charges, without a deductible, for routine physicals. There is no out-of-network benefit; you will be responsible for the entire cost.

l. SKILLED NURSING FACILITY

In-network, the Plan pays 100% of covered charges, without a deductible, subject to pre-authorization by the Plan. Out-of network, the plan pays 80% of the Schedule of Allowances after the deductible. Coverage is limited to a combined total of 50 days per member per year whether in-network or out-of network.

m. EYE CARE

In-network, after a $10 copayment, the Plan pays 100% of medically necessary charges. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for medically necessary eye care.

n. PROSTHETIC DEVICES

In-network, the Plan pays 100% of charges for internal prostheses and post-mastectomy prosthetics. Out-of-network, internal prostheses are covered as part of the inpatient hospital benefit. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for post-mastectomy prosthetics.

o. OUTPATIENT MENTAL HEALTH TREATMENT

In-network, after a $10 copayment, the Plan pays 100% of Medically Necessary Covered Services for outpatient mental health care. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible. In-network and out-of-network coverage is only available to participants who receive outpatient mental health care from a facility that has an operating certificate issued by the New York State Commissioner of Mental Health, a psychiatrist, a psychologist, a licensed clinical social worker, a professional corporation, or a university faculty practice plan.

Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for in-network or out-of-network coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

"Biologically Based Mental Illness" is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

"Children with Serious Emotional Disturbances" is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

p. OUTPATIENT CHEMICAL ABUSE OR DEPENDENCE TREATMENT

In-network, after a $10 copayment, the Plan pays 100% of covered expenses for outpatient alcohol and substance abuse treatment. Coverage for family therapy is available. Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

Out-of network, the Plan pays 80% of the Schedule of Allowances after the deductible for covered services, Family therapy benefits are available to any family member who is a plan participant even if the alcohol or substance abuser is not covered under this plan.

q. PHYSICIAN SURGICAL FEES

In-network, the Plan pays 100% of covered charges for surgical services provided by a physician, second surgical opinions, and anesthesia services. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

Breast Reconstruction After a Mastectomy
In-network, the Plan pays 100% of covered charges for breast reconstruction after a mastectomy including all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

r. PHYSICIAN MATERNITY FEES

In-network, the Plan pays 100% of covered charges for maternity services provided by a physician, except the initial office visit to determine pregnancy requires a $10 copayment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

s. WELL-CHILD CARE

In-network, the Plan will cover at 100% of covered charges. Out-of-network, but at a Participating Provider (within the broader BCBS network but not in the Point-of-service network), the Plan pays 100% of the Schedule of Allowances. For non-participating providers, the Plan pays 80% of the Schedule of Allowances after the deductible.

The following services rendered to a covered dependent from the date of birth through the attainment of nineteen years of age are covered by this benefit:

- an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians;

- at each visit, a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests;

- necessary immunizations for diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b, hepatitis b, varicella, hepatitis A (in selected geographic areas), and pneumococcal conjugate vaccine (Prevnar) and such other immunizations as are required under guidelines published by the Advisory Committee on Immunization Practices.

t. ADDITIONAL BENEFITS

In-network, the plan pays 100% with no deductible for Medically Necessary Covered Service**s** after a $10 co-payment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for the following Medically Necessary Covered Services**:**

(1) Allergy Treatment and Testing

(2) Second Cancer Opinion
A second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer. A second cancer opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer. If a participant receives services from an out-of-network specialist, the Plan will pay the out-of-network specialist's actual charge for the second cancer opinion. The participant will be required to pay the same coinsurance he or she would have paid if care was received from an in-network specialist.

(3) Chiropractic Care
Chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

(4) Diabetes
The following diabetes equipment and supplies when medically necessary: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. Diabetes self-management education when medically necessary. Education provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage also includes home visits when medically necessary.

(5) Diagnostic X-ray Coverage
Each laboratory examination and x-ray examination performed in connection with the diagnosis of an injury or illness.

(6) Routine Mammogram and Pap Smear
The Plan will cover 100% of covered charges for the following services:

- an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. The screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory

and diagnostic services provided in connection with examining and evaluating the Pap smear;

- Mammogram screenings are covered with no copayment for women of any age with a past history or family history of breast cancer upon the recommendation of a physician. Additional mammograms are covered as follows:
  - One baseline mammogram for women age 35-39 inclusive
  - One mammogram annually for women aged 40 and older

For purposes of this Plan, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

Routine mammograms and pap smears are available as an outpatient or in a physician's office.

(7) Standard diagnostic screening for prostate cancer.

The Plan will cover 100% of covered charges for diagnostic screening for prostate cancer when prescribed by a licensed practitioner, as follows:

(a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and

(b) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

(8) Diagnosis and Treatment of Infertility.

The Plan pays 100% of hospitalization and surgical care, laboratory tests, and FDA-approved drugs (after applicable prescription copay) and 80% of medical care for the diagnosis of infertility, provided, however, that the diagnosis of infertility will be conducted using standards and guidelines consistent with those adopted by the American Society for Reproductive Medicine (ASRM).

Under the Plan, infertility means the inability to conceive after twelve (12) consecutive months of frequent, contraceptive free unprotected intercourse with the intent to conceive. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years. Recurrent pregnancy loss is a disease distinct from infertility, defined by two or more failed pregnancies.

Infertility services means medical or surgical procedures which are medically necessary to diagnose or correct a malformation, disease, or dysfunction resulting in infertility, and diagnostic tests and procedures that are necessary to determine infertility, including but not limited to, hysterosalpinogram, hysteroscopy, endometrial biopsy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests, and ultrasound.

To be eligible for infertility services, the participant must: 1) be at least twenty-one (21) years of age and no older than forty-four (44) years of age except for the diagnosis and/or treatment for a correctable medical conditions which results in infertility, 2) have a treatment plan submitted in advance to the Plan by a physician who meets the applicable training, experience, and other standards for the diagnosis and treatment of infertility as set by New York State, 3) have a treatment plan that is in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetrics and Gynecology; and 4) receive preauthorization from the Plan.

Coverage does not include any of the following: 1) reversal of elective sterilization, 2) cloning or any services incident to cloning, 3) experimental infertility procedures, 4) sex change procedures, and 5) all costs associated with in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and any drugs, self-injectable or otherwise, used in conjunction with any of the above procedures.

(9) Bone Mineral Density Measurements and Testing.

The Plan will cover at 100% bone mineral density measurements and testing for both men and women who meet eligibility criteria established by Medicare or the National Institutes of Health for the detection of osteoporosis as follows:

(a) Bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal Medicare program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(b) For purposes of this subsection, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage, consistent with the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall, at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with a lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Coverage is subject to annual benefit limits under the Plan. FDA-approved drugs and devices for bone density are also covered under the Plan, subject to all deductibles and co-payments for prescription drugs or durable medical equipment.

(10) Preventive Colorectal Cancer Screening Tests.

The Plan covers at 100% the following preventive colorectal cancer screening tests:

- Fecal Occult Blood Testing (FOBT).
- Sigmoidoscopy.
- Colonoscopy.

The preventive coverage for the above tests is payable under the Plan in accordance with American Medical Association guidelines.

(11) Other Services

The following health care services when medically necessary:

- Blood (including transfusion and the cost of whole blood and blood components)
- Cardiac rehabilitation
- Chemotherapy
- Dialysis
- Hospice
- Rehabilative therapy (physical, occupational, and speech therapy) - limited to 20 aggregate visits per calendar year
- Podiatry (when medically necessary only. Routine foot care not covered)
- Private duty nursing (subject to prior authorization)
- Radiation therapy
- Respiratory therapy

4. Pregnancy And Maternity

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a

caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care.

F. SUMMARY OF MEDICAL BENEFITS – PREFERRED PROVIDER ORGANIZATION (PPO PLAN)

1. Description of Preferred Provider Organization Benefit

The plan administrator has contracted with selected healthcare providers to render quality medical care at agreed fees. There are financial incentives to the participant and the Plan when these in-network providers are utilized. A list of in-network providers is provided separately from this booklet and is available at your School Business Office or online at the Plan's website, www.mybenesite.com\ccsd.

For example, when in-network providers are utilized, the Plan pays for office visits at 100% with a $10 copayment. Payment for an out-of-network provider will be paid at 80% of the Schedule of Allowances after the annual deductible.

2. Out-of-Network Benefits are subject to Deductible and Co-insurance

a. Deductible

Each calendar year, before the Plan pays out-of-network benefits, you must satisfy an annual deductible: $250 individual / $500 family.

b. How the Family Deductible Works

The family deductible is designed to limit a family's annual outlay for covered expenses before the Plan begins to pay benefits. Each family member's (including a newborn's) covered expenses up to his or her per person deductible count toward the family deductible. Once this family deductible is met, the Plan will begin to pay benefits for all family members, including those who have not yet incurred expenses.

The Plan will also pay applicable benefits for any covered family member who meets the individual deductible, even if the total family deductible has not yet been met.

If two or more covered persons from the same family are injured in the same accident, only one deductible will be applied each year against the expenses incurred as a result of that accident.

c. 80% Reimbursement

After you have met your deductible the Plan reimburses 80% of the Schedule of Allowances of most out-of-network expenses. There are some specific exceptions to this rule that are described under specific benefit categories.

d. Out-of-Pocket Limit

Except as provided below, this is a cap on the amount of unreimbursed covered medical expenses you will have to pay in any one year. Once you reach your out-of-pocket limit, the Plan will pay 100% of the Schedule of Allowances for that year.

After the out-of-pocket limit has been reached for the year, you will still need to pay amounts your provider charges above the Schedule of Allowances or amounts exceeding Plan limits.

Most unreimbursed covered expenses for both you and your covered family members count toward your out-of-pocket limit. Unreimbursed covered expenses include deductible and coinsurance amounts-but do not include amounts your physician or health care provider may charge above the Schedule of Allowances or amounts exceeding Plan limits. Prescription drug copayments do not apply toward meeting the limit.

In any calendar year, the Plan limits each participant's out-of-pocket expenses to $2,000 per participant or $4,000 per family. As an example, to meet the individual out-of-pocket limit of $2,000, you generally must incur a total of $10,000 in covered medical expenses. Of this $10,000 you will pay $250 to meet your deductible and then 20% of each remaining covered expense until the total amount you have paid equals $2,000. Thus, in this example the total payment that you would be responsible for is equal to $2,000 ($250 deductible + $1,750 out-of-pocket limit). Once the family out-of-pocket limit is reached, all benefits (except for the limitations indicated above) will be paid at 100% for all family members including those who have not yet incurred any expenses.

3. Covered Benefits - PPO

a. PHYSICIAN OFFICE VISITS

In-network, after a $10 copayment, the Plan pays 100% of covered charges for office visit services provided by a physician, licensed physician's assistant or nurse practitioner. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

b. INPATIENT HOSPITAL CARE

In-network, the Plan pays 100% of covered charges. Out-of network, the Plan pays 80% of the Scheduled of Allowances after the deductible for these services.

The following services are covered services under the Inpatient Hospital benefit:

- Bed, board and general nursing services in a semi-private room, up to 365 days per confinement. A semi-private room is a room that the hospital considers to be semi-private. If you occupy a private room in a participating hospital, the Plan will cover up to the average charge for a semi-private room.
- Bed, board and general nursing services in a private room, if such room is deemed to be medically necessary.
- Use of operating, recovery and cystoscopic rooms and equipment.
- Use of intensive care or special care units and equipment.
- The administration and use of drugs, medications, sera, vaccines, intravenous preparations to the extent these items are commercially available and readily obtainable by the hospital.
- Dressings and plaster casts.
- Professional and equipment services in connection with the services listed below under the condition that the services are provided by a hospital employee and the charge for the services is payable to the hospital:

  - Oxygen
  - Physiotherapy
  - Laboratory and pathological examinations
  - Radiation therapy
  - Chemotherapy

- Use of equipment and supplies in connection with the services listed below.

  - Anesthesia
  - Electrocardiograms
  - Electroencephalograms
  - X-ray examinations

- Blood products, except when participation in a volunteer blood replacement program is available to you.
- Any additional medical services and supplies which are customarily provided by hospitals.
- Bed, board, general nursing services, the use of equipment and supplies in connection with a hospital stay for such period as is determined by the attending physician in consultation with the patient to be medically appropriate after such covered person has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Plan. Coverage for the length of stay in the hospital may not be restricted in a manner which is inconsistent with the coverage provided to the portion of the stay that preceded the lymph node dissection, lumpectomy or mastectomy. The Plan covers breast prosthetics and other complications of a mastectomy including lymphedemas.

c. EMERGENCY CARE

After a $50 copayment, the Plan pays for 100% of covered charges for an Emergency Illness as defined below. The copayment is waived if you are admitted to the hospital. An additional $50 copayment is required for non-emergency use of the emergency room. Emergency services are considered in-network even if a member accesses an out-of-network hospital.

An Emergency Illness is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (ii) serious impairment to such person's bodily functions, (iii) the serious dysfunction of any bodily organ or part of such person, or (iv) the serious disfigurement of such person.

d. CARE IN CONNECTION WITH OUTPATIENT SURGERY

In-network, the Plan pays for 100% of covered charges for facility and medical equipment services with no deductible for outpatient surgical procedures. Out-of-network the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

e. PRE-ADMISSION TESTING

In-network, the Plan will pay 100% of covered charges with no deductible. Out-of-network, the Plan will pay 80% of the Schedule of Allowances after payment of the deductible. The Plan covers tests ordered by a physician which are given to you before your admission to the hospital as a registered bed patient for surgery provided the following conditions are met:

- They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- You have made a reservation for the hospital bed and for the operating room before the tests are given;
- You are physically present at the hospital when the tests are given;
- Surgery actually takes place within 7 days after the tests were given.

f. HOME CARE

In-network, after a $10 copayment the Plan pays 100% of covered charges. Out-of network, the Plan will pay 80% of the Schedule of Allowances after payment of the deductible. Covered charges include services for care received in your home by certified or licensed Home Care agencies (as determined by New York State Public Health Law) under the following conditions:

- If you did not receive Home Care visits, you would have to be hospitalized in a hospital or cared for in a skilled nursing facility.
- A plan for your Home Care is established and approved in writing by a physician.

The following services are considered covered expenses under the Home Care benefit:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical, occupational or speech therapy if the Home Care Agency or hospital provides these services.
- Medical supplies, drugs and medications prescribed by a doctor, but only if these items are covered if you are confined in a hospital or skilled nursing facility.
- Laboratory services provided by or on behalf of the Home Care Agency or hospital.
- Up to 365 visits in each calendar year. Each visit by a member of a Home Care team is counted as one Home Care visit. Four hours of home health aide service is counted as one Home Care visit.

g. AMBULANCE

Medically Necessary transportation in an ambulance is covered at 100% after a $50 copayment. All Medically Necessary transportation in an ambulance is considered to be an in-network benefit.

The Plan covers prehospital emergency medical services at the Emergency Care benefit level (see Section c. above) when such services are provided by a certified ambulance service.

"Prehospital emergency medical services" means the prompt evaluation and treatment of an Emergency Illness (as defined in Section c. above) and/or non-air-borne transportation to a hospital; provided however, where the patient utilizes non-air-borne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

h. INPATIENT MENTAL HEALTH CARE

In-network, the Plan pays 100% of covered charges for Active Treatment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for Active Treatment. “Active Treatment” is defined as treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the New York State Commissioner of Mental Health. Active Treatment must be provided in a hospital defined in Section 1.03(10) of the New York Mental Hygiene Law. Partial hospitalization is also covered, however, two partial hospitalizations days are equal to one covered inpatient day.

Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

“Biologically Based Mental Illness” is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

“Children with Serious Emotional Disturbances” is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

i. INPATIENT ALCOHOL AND SUBSTANCE ABUSE

In-network, the Plan pays 100% of covered charges for inpatient detoxification. Out-of-network, the Plan pays 80% of the Schedule of Allowances for inpatient detoxification after the deductible.

j. LABORATORY

In-network, the Plan pays 100% of covered charges, without a deductible, for each laboratory examination performed in connection with the diagnosis of an injury or illness at a participating facility. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible, up to a maximum of $100 per participant per year.

k. PHYSICALS

In-network, after a $10 copayment, the Plan pays 100% of covered charges, without a deductible, for routine physicals. There is no out-of-network benefit; you will be responsible for the entire cost.

l. SKILLED NURSING FACILITY

In-network, the Plan pays 100% of covered charges, without a deductible, subject to pre-authorization by the Plan. Out-of-network, the plan pays 80% of the Schedule of Allowances after the deductible subject to pre-authorization by the Plan. Coverage is limited to a combined total of 50 days per member per year whether in-network or out-of network.

m. EYE CARE

In-network, after a $10 copayment, the Plan pays 100% of medically necessary charges. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for medically necessary eye care.

n. PROSTHETIC DEVICES

In-network, the Plan pays 100% of charges for internal prostheses and post-mastectomy prosthetics. Out-of-network, internal prostheses are covered as part of the inpatient hospital benefit. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for post-mastectomy prosthetics.

o. OUTPATIENT MENTAL HEALTH TREATMENT

In-network after a $10 copayment, the Plan pays 100% of covered expenses for outpatient mental health care. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible. In-network and out-of-network coverage is only available to participants who receive outpatient mental health care from a facility that

has an operating certificate issued by the New York State Commissioner of Mental Health, a psychiatrist, a psychologist, a licensed clinical social worker, a professional corporation, or a university faculty practice plan.

Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for in-network or out-of-network coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

"Biologically Based Mental Illness" is defined as a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under New York law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

"Children with Serious Emotional Disturbances" is defined as those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotion disturbances that placed the child at substantial risk of removal from the household.

p. OUTPATIENT CHEMICAL ABUSE OR DEPENDENCE TREATMENT

In-network, after a $10 copayment, the Plan pays 100% of covered expenses for outpatient alcohol and substance abuse treatment. Family therapy benefits are available to any family member who is a plan participant even if the alcohol or substance abuser is not covered under this Plan. Participants must obtain pre-authorization by the Plan's mental health benefit manager to be eligible for in-network or out-of-network coverage. The Plan's mental health benefit manager must also coordinate the care that is provided.

Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for covered services. Family therapy benefits are available to any family member who is a plan participant even if the alcohol or substance abuser is not covered under this Plan.

q. PHYSICIAN SURGICAL FEES

In-network, the plan pays 100% of covered charges for surgical services provided by a physician, second surgical opinions, and anesthesia services. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

Breast Reconstruction After a Mastectomy
In-network, the plan pays 100% of covered charges for breast reconstruction after a mastectomy including all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

r. PHYSICIAN MATERNITY FEES

In-network, the plan pays 100% of covered charges for maternity services provided by a physician, except the initial office visit to determine pregnancy requires a $10 copayment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for these services.

s. WELL-CHILD CARE

In-network, the plan will cover at 100% of covered charges. Out-of-network the Plan pays 80% of the Schedule of Allowances after the deductible.

The following services rendered to a covered dependent from the date of birth through the attainment of nineteen years of age are covered by this benefit:

- an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians;

- at each visit, a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests;

- necessary immunizations for diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b, hepatitis b, varicella, hepatitis A (in selected geographic areas), and pneumococcal conjugate vaccine (Prevnar)and such other immunizations as are required under guidelines published by the Advisory Committee on Immunization Practices.

t. ADDITIONAL COVERED SERVICES

In-network, the plan pays 100% with no deductible for covered charges after a $10 co-payment. Out-of-network, the Plan pays 80% of the Schedule of Allowances after the deductible for the covered charges.

The following services are covered:

(1) Allergy Treatment and Testing

(2) Second Cancer Opinion

A second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer. A second cancer opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer. If a participant receives services from an out-of-network specialist, the Plan will pay the out-of-network specialist's actual charge for the second cancer opinion. The participant will be required to pay the same coinsurance he or she would have paid if care was received from an in-network specialist.

(3) Chiropractic Care

Chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column**.**

(4) Diabetes

The following diabetes equipment and supplies when medically necessary: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, cartridges for the visually impaired, injection aids, insulin pumps and appurtenances thereto, insulin infusion devices. Diabetes self-management education when medically necessary. Education provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage also includes home visits when medically necessary. Insulin, syringes, and oral agents for controlling blood sugar are covered under the Prescription Benefit Copay.

(5) Diagnostic X-ray Coverage

Each laboratory examination and x-ray examination performed in connection with the diagnosis of an injury or illness.

(6) Routine Mammogram and Pap Smear

The Plan will cover 100% of covered charges for the following services:

- an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. The screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear;

- Mammogram screenings are covered with no copayment for women of any age with a past history or family history of breast cancer upon the recommendation of a physician. Additional mammograms are covered as follows:
    - One baseline mammogram for women age 35-39 inclusive
    - One mammogram annually for women aged 40 and older

For purposes of this Plan, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

Routine mammograms and pap smears are available as an outpatient or in a physician's office.

(7) Standard diagnostic screening for prostate cancer.

The Plan will cover 100% of covered charges for diagnostic screening for prostate cancer when prescribed by a licensed practitioner, as follows:

(a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and

(b) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

(8) Diagnosis and Treatment of Infertility.

The Plan pays 100% of hospitalization and surgical care, laboratory tests, and FDA-approved drugs (after applicable prescription copay) and 80% of medical care for the diagnosis of infertility, provided, however, that the diagnosis of infertility will be conducted using standards and guidelines consistent with those adopted by the American Society for Reproductive Medicine (ASRM).

Under the Plan, infertility means the inability to conceive after twelve (12) consecutive months of frequent, contraceptive free unprotected intercourse with the intent to conceive. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years. Recurrent pregnancy loss is a disease distinct from infertility, defined by two or more failed pregnancies.

Infertility services means medical or surgical procedures which are medically necessary to diagnose or correct a malformation, disease, or dysfunction resulting in infertility, and diagnostic tests and procedures that are necessary to determine infertility, including but not limited to, hysterosalpinogram, hysteroscopy, endometrial biopsy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests, and ultrasound.

To be eligible for infertility services, the participant must: 1) be at least twenty-one (21) years of age and no older than forty-four (44) years of age except for the diagnosis and/or treatment for a correctable medical conditions which results in

infertility, 2) have a treatment plan submitted in advance to the Plan by a physician who meets the applicable training, experience, and other standards for the diagnosis and treatment of infertility as set by New York State, 3) have a treatment plan that is in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetrics and Gynecology; and 4) receive preauthorization from the Plan.

Coverage does not include any of the following: 1) reversal of elective sterilization, 2) cloning or any services incident to cloning, 3) experimental infertility procedures, 4) sex change procedures, and 5) all costs associated with in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and any drugs, self-injectable or otherwise, used in conjunction with any of the above procedures.

(9) Bone Mineral Density Measurements and Testing.

The Plan will cover at 100% bone mineral density measurements and testing for both men and women who meet eligibility criteria established by Medicare or the National Institutes of Health for the detection of osteoporosis as follows:

(a) Bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal Medicare program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(b) For purposes of this subsection, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage, consistent with the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall, at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with a lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Coverage is subject to annual benefit limits under the Plan. FDA-approved drugs and devices for bone density are also covered under the Plan, subject to all deductibles and co-payments for prescription drugs or durable medical equipment.

(10) Preventive Colorectal Cancer Screening Tests.

The Plan covers at 100% the following preventive colorectal cancer screening tests:

- Fecal Occult Blood Testing (FOBT).
- Sigmoidoscopy.
- Colonoscopy.

The preventive coverage for the above tests is payable under the Plan in accordance with American Medical Association guidelines.

(11) Other Services

The following health care services when medically necessary:

- Blood (including transfusion and the cost of whole blood and blood components)
- Cardiac rehabilitation
- Chemotherapy
- Dialysis
- Hospice
- Rehabilative therapy (physical, occupational, and speech therapy) - limited to 20 aggregate visits per calendar year
- Podiatry (when medically necessary only. Routine foot care not covered)
- Private duty nursing (subject to prior authorization)
- Radiation therapy
- Respiratory therapy

4. Pregnancy And Maternity

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care.

G. MEDICAL PLAN EXCLUSIONS

The following are not covered expenses under the Medical Plan:

- Travel expenses
- Cosmetic services and procedures (except for medically necessary cosmetic services and procedures and reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved body part or reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect)
- Services or care in connection with toenails (except full removal), corns, calluses; weak, strained or flat feet; fallen arches; instability or imbalance of the foot
- Marriage or vocational counseling
- Services rendered for custodial care
- Special clothing, including orthopedic shoes
- Household equipment
- Special food, diets, and food supplements (except for enteral formulas and modified solid food products)
- Equipment repairs and adjustments, unless due to a physical change

- Routine eye examinations, eyeglasses and contact lenses, except following cataract surgery or injuries sustained while covered by the Plan, in which case benefits will be available for the contact lenses or regular lenses exclusive of frames
- Hearing aids
- Services provided under the Federal Employer's Liability Act, Worker's Compensation Act or similar legislation, or under a No-Fault Insurance Policy
- Services for which there is no cost to the participant
- Research or experimental procedures including services and equipment unless directed pursuant to external review
- Acupuncture
- Hypnosis
- Costs incurred while under an act-of-war
- Injuries or illness arising from the commission of a felony
- Any services or care for which coverage is available in whole or in part under another health benefits contract or rider, except Medicaid or another plan that by its terms does not permit coordination of benefits
- Services furnished to the covered person before the effective date of their coverage
- Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, alveolar processes, treatment to the repair or the replacement of a denture or other dental treatment unless medical in nature; benefits will be payable for the surgical and the anesthesia charges incurred for the removal of impacted teeth, or for such care or treatment due to accidental injury to sound, natural teeth within 12 months of the accident or a congenital disease or anomaly
- Any deductibles or coinsurance under the Plan
- Elective abortions
- Services which are not medically necessary
- Charges in excess of the Schedule of Allowances
- Care or treatment for which payment is made by any local, state, or federal government agency, including Medicare
- Professional services performed by a member of the covered person's immediate family
- Massage Therapy except when deemed to be medically necessary by a physician and performed in the office of a physician or chiropractor

SECTION IV

PRESCRIPTION PLAN

A. SUMMARY OF PRESCRIPTION DRUG BENEFITS

1. Cost Sharing Options (Retail and Mail Order)

Prescription Drug coverage is provided through either the Major Medical benefit or through a Prescription Drug Card Plan. The prescription drug plan available to you depends on the terms and conditions of your individual districts.

a. Major Medical

Under the Major Medical option, prescription drugs are covered at 80%, subject to the annual deductible and out-of-pocket maximum as described in the Summary of Medical Benefits Section. Your prescription drug plan ID card is the same as your medical plan ID card.

b. Prescription Drug Card Plan

There are 14 options for the Prescription Drug Card Plan. The option available to you depends on the terms and conditions of your individual districts. Each of the options described below show the amount you pay for each prescription:

- **Option 1:** $1.00 copay(generic or brand name drugs);
  Retail (up to a 35 day supply): $1.00 per prescription (generic or brand name drugs) Mail Order (up to a 105 day supply): $1.00 per prescription (generic drugs or brand name drugs) or

- **Option 2:** $5.00 copay (generic or brand name drugs);
  Retail (up to a 35 day supply): $5.00 per prescription (generic or brand name drugs) Mail Order (up to a 105 day supply): $5.00 per prescription (generic or brand name drugs) or

- **Option 3:** $5.00 (generic drugs) / $10.00 (brand name drugs) copay
  Retail (up to a 35 day supply): $5.00 per generic and $10 per brand name prescription: Mail Order (up to a 105 day supply) $5.00 per generic prescription and $10 copay per brand name prescription or

- **Option 4:** 20% coinsurance up to a maximum of $100 per calendar year. After you have paid $100 towards your prescriptions in a calendar year, the plan will pay 100% of covered charges: Retail (up to 35 day supply) Mail Order (up to 105 day supply)

- **Option 5:** $7.00 copay (generic or brand name drugs);
  Retail (up to a 30 day supply): $7.00 per prescription (generic or brand name drugs) Mail Order (up to a 90 day supply): $14.00 per prescription (generic or brand name drugs) or

- **Option 6:** $10.00 copay (generic or brand name drugs);
  Retail (up to a 30 day supply): $10.00 per prescription (generic or brand name drugs) Mail Order (up to a 90 day supply): $20.00 per prescription (generic or brand name drugs) or

- **Option 7:** $5.00 (generic drugs) / $10.00 (brand name drugs) copay per prescription after $250 deductible
  Retail (up to a 30 day supply): $5.00 per generic and $10.00 per brand name prescription: Mail Order (up to a 90 day supply) $10.00 per generic prescription and $20.00 per brand name prescription

- **Option 8:** $3.00 (generic drugs) / $10.00 (preferred brand name drugs) / $20.00 (non-preferred band name drugs) copay
  Retail (up to a 30 day supply): $3.00 per generic, $10.00 per preferred brand name and $20.00 per non-preferred brand name prescription: Mail Order (up to a 90 day supply) $6.00 per generic, $20.00 per brand name and $40.00 per non-preferred brand name prescription

- **Option 9:** $7.00 (generic drugs) / $15.00 (preferred brand name drugs) / $35.00 (non-preferred band name drugs) copay
  Retail (up to a 30 day supply): $7.00 per generic, $15.00 per preferred brand name and $35.00 per non-preferred brand name prescription: Mail Order (up to a 90 day supply) $14.00 per generic, $30.00 per brand name and $70.00 per non-preferred brand name prescription

- **Option 10:** $10.00 (generic drugs) / $20.00 (brand name drugs) copay
  Retail (up to a 30 day supply): $10 per generic and $20.00 per brand name prescription: Mail Order (up to a 90 day supply $20.00 per generic prescription and $40.00 per brand name prescription

- **Option 11:** $10.00 (generic drugs) / $20.00 (preferred brand name drugs) / $40.00 (non-preferred band name drugs) copay
  Retail (up to a 30 day supply): $10.00 per generic, $20.00 per preferred brand name and $40.00 per non-preferred brand name prescription: Mail Order (up to a 90 day supply) $20.00 per generic, $40.00 per brand name and $80.00 per non-preferred brand name prescription

- **Option 12:** 20% coinsurance up to a maximum of $250 per calendar year.
  After you have paid $250 towards your prescriptions in a calendar year, the plan will pay 100% of covered charges. Retail (up to 30 day supply) Mail Order (up to 90 day supply)

The following 2 options are only available in conjunction with the POS and PPO Plans:

- **Option 13:** $7.00 (generic drugs) / $15.00 (brand name drugs) copay
  Retail (up to a 30 day supply): $7 per generic and $15.00 per brand name prescription: Mail Order (up to a 90 day supply) $14.00 per generic prescription and $30.00 per brand name prescription

- **Option 14:** $5.00 (generic drugs) / $10.00 (preferred brand name drugs) / $25.00 (non-preferred band name drugs) copay
  Retail (up to a 30 day supply): $10.00 per generic, $20.00 per preferred brand name and $40.00 per non-preferred brand name prescription: Mail Order (up to a 90 day supply) $10.00 per generic, $20.00 per brand name and $50.00 per non-preferred brand name prescription

Under the Prescription Card Drug Plan, you will receive a separate Prescription Plan ID card from the Prescription Plan Supervisor.

2. Participating and Non-Participating Pharmacies

If the prescription order for drugs covered under this program is filled, or if the insulin is obtained, at a participating pharmacy, the covered individual will pay only the copay/coinsurance applicable to the participant's school district for each prescription order or supply of insulin, upon presentation of the prescription drug ID card at the time of purchase. A "participating pharmacy" is a pharmacy which is registered as a pharmacy with the appropriate State licensing agency and which has an agreement with the Plan's Prescription Plan Supervisor to dispense drugs and insulin under the Prescription Drug Program.

Purchase of drugs at non-participating pharmacies requires that the participant pay that pharmacy's charge, obtain a receipt, and fill out a claim form. Reimbursement will be, as determined by Prescription Plan Supervisor's book-of-business data, at the lower of the average cost for the drug within the community in or near which it was filled, or the non-participating pharmacy's actual charge, less the applicable co-pay.

If you are unsure whether a pharmacy is participating in the network, you can call the toll free number on the back of your prescription drug identification card.

3. Limits on Dispensing Prescription Drugs

The quantity of drugs dispensed at a retail pharmacy under any one prescription order under this program cannot exceed a supply sufficient to provide the prescription dosage for up to either thirty (30) or thirty-five (35) consecutive days depending on the drug card option.

Some prescriptions may require prior authorization from the Prescription Plan Supervisor before they are dispensed or may have quantity limits less than 30 or 35 consecutive days due to the nature of the drug and its efficacy.

Prescription orders for maintenance drugs may be dispensed in a supply sufficient to provide the prescribed drug for up to 105 consecutive days (depending on the drug card option). A "maintenance drug" is an antiarthritic drug, anticoagulant drug, an anticonvulsant drug, a hormone, a thyroid preparation, a cardiac drug or any other drug specifically designated as a chronic drug.

4. Mail Order Service

Another option is the mail order service, which allows participants to order up to either a 90 or 105 day supply (depending on the drug card option) of a prescription medicine (where designated as "refill") by mail. To use the mail order service, send your prescription and a check, credit card number or money order for your co-pay for the cost of the medication, in the mail order envelope.

5. Step Therapy

Step Therapy is a program especially for people who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. The program moves you along a well-planned path, with your doctor approving your medications. This first step lets you begin or continue treatment with prescription drugs that are more cost effective. If your path requires more medications, then the program moves you along to this next step. Contact your individual school district to see if your prescription drug plan follows step therapy.

6. Roll Back

Some prescription options allow for roll back. Roll back occurs when you submit your prescription copays to the major medical plan for reimbursement. If rollback applies, the reimbursement is 80% of the copay after the applicable major medical calendar year deductible. Contact your individual school district to see if your prescription drug plan allows roll back.

7. Brand And Generic Drugs

Please note that unless your physician specifically prescribes a brand-name medicine, the pharmacist will fill your prescription with a generic equivalent, in accordance with New York State law.

8. Enteral Formulas And Modified Solid Food Products

The plan covers, subject to deductibles, coinsurance and co-payments as described above, the cost of enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe has issued a written order. Such written

order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. Specific diseases for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any covered individual shall not exceed two thousand five hundred dollars.

Contraceptive Drugs and Devices – See separate Contraceptive Drugs and Devices Rider

B. PRESCRIPTION DRUG EXCLUSIONS

No coverage under the prescription drug benefit will be made for the following:

- Drugs which do not require a written prescription, except insulin
- Mechanical devices such as artificial appliances and therapeutic devices
- Administration or injection of any drug, unless administered in a physician's office
- Vitamins, diet supplements, and similar items (except for prenatal vitamins, enteral formulas and modified solid food products)
- Drugs which are designated by Federal or New York State Law as experimental or investigational unless directed pursuant to external appeal. Coverage for a drug approved by the FDA will be provided even if it has not been approved for the treatment of the specific type of cancer that the covered persons suffers from, so long as the drug is recognized for treatment of that specific type in the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, the United States Pharmacopeia Drug Information, or recommended by article or editorial comment in a major peer-reviewed professional journal.
- Blood or plasma
- Drugs dispensed to an enrollee while a hospital patient
- Drugs dispensed to an enrollee while a patient at a nursing home or institution, if cost of the drug is billed by the nursing home or institution
- Drugs provided under any Federal or State Law including any Worker's Compensation Act or similar law (except Medicaid)

C. PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION The following medications require prior authorization:

Epogen
Procrit
Enbrel
Lupron
Infertility Medications
Wellbutrin 100 mg & 150 mg
Chorionic Gonadotropin
Growth Hormones
Retin – A
Immune Globulins
Any 2nd line step therapy medication

This list is subject to change. Participants may obtain updated information by contacting the Prescription Plan Supervisor identified in Section VII General Information.

Certain medications have a quantity limit and prior authorization is required to receive a higher quantity. Participants may obtain a list of such drugs at www.express-scripts.com.

It is the participant's responsibility to contact his or her physician who will contact the Plan for prior authorization of the above referenced drugs.

SECTION VII

GENERAL INFORMATION

VII. GENERAL INFORMATION

A. HOW TO FILE A CLAIM

1. Medical

How you file a claim depends on both your employment status and your Medicare eligibility. The claim filing procedure is the same regardless if the coverage is under the Basic or Major Medical option.

a. IF YOU ARE AN ACTIVE PARTICIPANT OR A RETIREE NOT ELIGIBLE FOR MEDICARE

Claims for all medical services should be sent to the Medical Plan Supervisor. If you receive services from a hospital within New York State, present your Medical Plan Identification Card during the admission procedures. This will allow the hospital to forward the bill to the Medical Plan Supervisor for payment as well as receive payment from the Medical Plan Supervisor directly.

For services received from a non-participating hospital, the hospital will send you the bill. You should forward the itemized bill to the Medical Plan Supervisor at the address listed in Section VII General Information.

Be sure to include your subscriber and group number on the bill. Both these numbers are found on your medical plan Identification Card. All claims must be submitted for consideration within 15 months of the date on which services were provided. Claims older than 15 months will be denied.

b. IF YOU ARE A RETIREE WHO IS ELIGIBLE FOR MEDICARE

All claims should be submitted to Medicare FIRST. Present your Medicare card at the time you receive services. For hospital services, also present your Medical Plan Identification Card; this will allow the hospital to bill the Medical Plan Supervisor directly after it receives payment from Medicare. Should the hospital bill you directly instead of sending the bill to the Medical Plan Supervisor, submit both the itemized hospital bill and the Medicare explanation of benefits (EOB) to the Medical Plan Supervisor for payment consideration.

Once you receive the Medicare EOB, submit both the itemized bill and the Medicare EOB as outlined in the "If you are an active participant OR a retiree not eligible for Medicare" section above.

(1) When Medicare is the Secondary Payer

Medicare will pay in a secondary position in the following circumstances:

- The services are reimbursable under automobile medical, no fault or any liability insurance;

- The Medicare beneficiary is 65 or older and has employer group health plan coverage through his or her own employment or the employment of a spouse (of any age);
- The Medicare beneficiary is entitled to Medicare solely on the basis of end-stage renal disease (ESRD); in this instance, Medicare is secondary to an employer group health plan for a period of up to 30 months after the individual has been determined to be eligible for ESRD benefits; or
- The Medicare beneficiary is disabled (except in the case of ESRD) and elects to be covered by an employer group health plan as a current employee of an employer with 100 or more employees or the family member of such employee.

c. BLUE CARD PRICING DISCLOSURE

When you obtain health care services from a participating provider outside the geographic area BlueCross BlueShield of Western New York serves, the amount you pay for covered services is calculated on either:

- The billed charges for your covered services, or

- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to the Plan.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price considered by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, and other contingent payments arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices, however, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual Blue Card method or require a surcharge, BlueCross BlueShield of Western New York would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area BlueCross BlueShield of Western New York serves, if this plan covers those health care services. Due to variations in Host Blue medical

practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area Blue Cross BlueShield serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area BlueCross BlueShield of Western New York serves. But in no event will you be entitled to benefits for health care services, whenever you receive them, which are specifically excluded or limited from coverage by this plan.

2. Prescription Drug

RETAIL PROGRAM (Participating and Non Participating Pharmacies)

You will receive member ID cards and a listing of the Participating Pharmacies in Chautauqua County. You must present your ID card to your pharmacist each time you receive a prescription medication. You can also call the toll free number on your ID card to locate participating pharmacies anywhere in the country.

If you visit a participating pharmacy, there is no claim filing; you simply pay the pharmacy your copayment/coinsurance.

For non-participating pharmacies, you will need to pay the pharmacy in full for your prescription and send the claim to the Prescription Drug Supervisor for reimbursement. Be sure to include the original prescription receipt that shows the date, who the prescription is for, the drug prescribed and the quantity prescribed.

MAIL SERVICE PROGRAM (Participating pharmacies only)

For any of the available copayment plans, to use the mail service, complete the mail service patient profile for each covered family member, and mail it along with your original prescription and applicable copayment. (You will need to contact your physician to obtain a new prescription for any medications you currently take. Have your physician write the prescription for a three month (90 or 105 day – depending on Prescription Drug option) supply, with up to three refills. In many cases, your physician will be able to arrange for a new prescription without requiring an office visit.)

For the prescription card plan 20% coinsurance option, you may call the Prescription Plan Supervisor to determine your applicable cost for mail order prescriptions. You may also be able to charge your prescriptions to a credit card through the mail order program. (You will need to contact your physician to obtain a new prescription for any medications you currently take. Have your physician write the prescription for a three month (90 or 105 day – depending on Prescription Drug option) supply, with up to three refills. In many cases, your physician will be able to arrange for a new prescription without requiring an office visit.)

For new prescriptions, once you have submitted a member profile, you can either mail the original prescription, or have your physician fax it directly to the mail service facility.

PRESCRIPTIONS COVERED UNDER MAJOR MEDICAL

If you do not have a prescription card plan available and your prescription coverage is provided through the Major Medical option, you can submit your prescription claims the same way you submit any other medical expense through the Major Medical option.

PRESCRIPTION CARD PLAN COPAYS

Some copays you are responsible for under the prescription card program (Rx Card Options 1-3) can be submitted for coverage under the Major Medical option. If you have the 20% coinsurance option (Option 4) under the prescription card plan, you *may not* submit your coinsurance amounts to the Major Medical option for reimbursement.

B. CLAIM APPEAL PROCEDURES

If a claim is denied in whole or in part, the covered person will receive notification delivered in the same manner as reimbursement for a claim.

The insurance carrier will provide an explanation of benefits (EOB). The EOB will show the calculation of the total amount payable, any charges not payable and the reason for charges not payable. If additional information is needed for consideration of a claim, the insurance carrier will request it.

If an exception is taken to a denied claim and it cannot be resolved to the individual's satisfaction, the individual will be referred to the local school advisory committee. A claim review may be obtained by filing a written request with the local school advisory committee, which will then file the claim review with the Plan Administrator.

On receipt of a written request for review of a claim, the Plan Administrator will review the claim and be furnished with copies of all pertinent documents (except any information in the participant's claim history which the participant or physician does not wish to be made known). Please contact your district's business office to determine where you may submit opinions of what the issues are and any comments.

1. Utilization Review Procedure

This section explains our utilization review procedure. Utilization review (UR) decisions relate to the medical necessity of care, including the appropriateness of the level of care or the provider of care; or to the experimental and/or investigational nature of care. UR decisions are made when prior authorization is requested for care (the "prospective review process"), during the course of care (the "concurrent review process"), and after care is rendered (the "retrospective review process").

Examples of cases that would be reviewed under the UR procedure include our refusal of prior authorization for an inpatient hospital stay because the care is available on an outpatient basis; or our determination that you can be released from a hospital because your condition no longer requires you to have 24-hour nursing service; a determination

that continued or extended home health care services following an inpatient hospital stay are not medically necessary; or our determination that the treatment you received is experimental and/or investigational (including clinical trials and treatments for rare diseases), in light of your condition.

The steps of the UR procedure are as follows:

a. PRIOR AUTHORIZATION PROCESS

All requests for prior authorization of care are reviewed to determine medical necessity (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is experimental and/or investigational. The initial review is performed by a nurse. If the nurse determines that the proposed care is medically necessary and not experimental and/or investigational, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or is experimental and/or investigational, or that further evaluation is needed, the nurse will refer the case to a clinical peer reviewer (a physician who possesses a current and valid nonrestricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One Internal appeal (described in "Review of Adverse Determinations", below).

Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to you or your authorized designee, and your provider, by telephone and in writing, within 3 business days following receipt of all information necessary to make the decision.

Where utilization review is relied upon to make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, the nurse or clinical peer reviewer shall provide notice of the determination within one business day of the receipt of the necessary information, except with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Provided that a request for home health care services and all necessary information is submitted prior to discharge from an inpatient hospital admission, the nurse or clinical peer reviewer shall not deny on the basis of medical necessity or lack of prior authorization, coverage for home health services while the review is pending. Notification of continued or extended services shall include the number of extended

services approved, the new total of approved services, the date of onset of services, and the next review date.

The notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to a review of the adverse determination, give instructions for initiating standard and expedited internal and external appeals, and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify additional information or documentation, if any, needed for us to make a level One internal appeal determination.

If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request of reconsideration, in consultation with the requesting provider. A request for reconsideration by your provider does not prevent you from filing an appeal at the same time. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within 3 business days from the date of reconsideration. All of the information described in the paragraph above will be included in this notice.

b. CONCURRENT REVIEW PROCESS

When you are receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and experimental and/or investigational nature of services you receive throughout the course of treatment.

Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary and not experimental and/or investigational. If so, the nurse will authorize care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (defined in "Prior Authorization Process" above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal (described in "Review of Adverse Determinations" below).

Your provider will be notified of the concurrent review decision, by telephone and in writing, within 1 business day following our receipt of all information or documentation needed for the review. Where utilization review is relied upon to make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, the nurse or clinical peer reviewer shall provide notice of the determination within one business day of the receipt of the necessary information, except with respect to home health care services following an inpatient hospital

admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Provided that a request for home health care services and all necessary information is submitted prior to discharge from an inpatient hospital admission, the nurse or clinical peer reviewer shall not deny on the basis of medical necessity or lack of prior authorization, coverage for home health services while the review is pending. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will advise you of your right to a review of the adverse determination, give instructions for initiating standard and expedited internal and external appeals, and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify additional information or documentation needed, if any, for us to make a Level One Internal appeal determination.

If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. A request for reconsideration by your provider does not prevent you from filing an appeal at the same time. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within 1 business day from the date of reconsideration. All of the information described in the paragraph above will be included in this notice.

c. <u>RETROSPECTIVE REVIEW PROCESS</u>

At our option, a nurse will review retrospectively the medical necessity and the experimental and/or investigational nature of services, which are subject to utilization review. If the nurse determines that care you received was medically necessary and not experimental and/or investigational, the nurse will authorize benefits. If the nurse determines that the care was not medically necessary or was experimental and/or investigational, the nurse will refer the case to a clinical peer reviewer (defined in "Prior Authorization Process" above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One Internal appeal (described in "Review of Adverse Determinations" below).

You or your authorized designee and your provider will be notified of the retrospective review determination, in writing, within 30 calendar days from our

receipt of all information or documentation needed for the review. Where utilization review is relied upon to make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, notice of the determination shall be provided within one business day of the receipt of the necessary information, except with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday.

The notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will advise you of your right to request a review of the adverse determination, give instructions for initiating standard and expedited internal or external appeals, and specify that you or your authorized designee may request a copy of the clinical review criteria used by us to make the adverse determination. The notice will also specify additional information or documentation needed, if any, for us to make a Level One internal appeal determination.

The provider who rendered care for which benefits are denied may request a Level One internal appeal of the retrospective adverse determination on your behalf (even if not authorized in writing by you to act as your designee).

d. <u>REVIEW OF ADVERSE DETERMINATIONS</u>

(1) Request for Level One Internal Appeal

You, your authorized designee, and, in a retrospective review case, your health care provider may request a Level One internal appeal of an adverse determination, verbally or in writing, within 45 days from the date that you receive notice of the adverse determination. (If the notice you received did not specify all information required to conduct a Level One internal appeal, the time period for you to request the review will be extended.) To request a Level One internal appeal verbally, you may call the plan administrator, or visit us in person. To submit a written request for Level One internal appeal, you may write to the plan administrator.

The procedure that we will follow in reviewing your case will differ, depending upon the urgency of the case. In most cases, a standard Level One internal appeal, described below, will be appropriate. In "urgent cases," an expedited Level One appeal is available; expedited Level One internal appeal is described after standard Level One internal appeal below.

(2) Standard Level One Internal Appeal

We will acknowledge your Level One internal appeal in writing, within 15 days after receiving it. The acknowledgment will advise you of the department (including the address and telephone number) designated to respond to the appeal.

When one or more Level One internal appeals are received (for example, you submit an appeal, then your health care provider submits an appeal on your behalf), a single Level One internal appeal will be conducted by a clinical peer reviewer (a physician who possesses a current and valid nonrestricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition), who did not make the initial adverse determination.

The clinical peer reviewer will render a determination within 30 calendar days after receipt of all necessary information. Written notice of the determination will be provided to you and any other qualified party who submitted a Level One internal appeal within 2 business days after the determination is made, but in no event later than 60 calendar days after receiving all necessary information. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

The notice will include detailed reasons and the clinical rationale for the determination. If the determination is adverse, the notice will describe the procedure for filing a Level One internal appeal. It will also describe the process, and enclose an application, for requesting an external appeal of the adverse determination. The external appeal process is described below. If you submit a Level Two internal appeal, the appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of Level One internal appeal.

(3) Expedited Level One Appeal

For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission; or any other issue with respect to which a provider requests an immediate review), you, your authorized designee, or a provider may request an expedited Level One internal appeal of the initial adverse determination.

When a request for expedited Level One internal appeal is received, the appeal will be conducted by a clinical peer reviewer (defined in "Standard Level One Internal Appeal" above) who did not render the initial adverse determination. The Customer Service Department will provide reasonable access to the clinical peer reviewer assigned to the appeal, within 1 business day following receipt of notice of the request for appeal, to ensure that all relevant information in available to the clinical peer reviewer. You may ask that your provider and the clinical peer reviewer exchange information by telephone or fax.

Within 2 business days of receipt by us of all information needed for the appeal, the clinical reviewer will render a determination on the expedited Level One internal appeal. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

Notice will be provided to you and the provider, by telephone and in writing, within 24 hours of the determination. The notice will include all of the information described and enclosed in a notice of standard Level One internal appeal determination (see "Standard Level One Internal Appeal" above). Note – If you request a Level Two internal appeal, which is optional, the appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of Level One internal appeal.

(4) Level Two Internal Appeal

After you receive notice of a Level One internal appeal determination, if you are still not satisfied, you or your authorized designee may submit a Level Two internal appeal, verbally or in writing. (You also have an option to apply for an external appeal; see "External Appeal" below). The Level Two internal appeal must be received by us within 60 business days from the date of the Level One internal appeal determination.

We will acknowledge your Level Two internal appeal, in writing, within 15 calendar days after receiving it. The acknowledgement will advise you of the department (including the address and telephone number) designated to respond to the appeal, and will identify additional information, if any, needed for the Level Two appeal.

Your case will be reviewed by at least one clinical peer reviewer (defined in "Standard Level One Internal Appeal" above) who did not make the prior determinations.

In "urgent cases," where a delay would significantly increase the risk to your health, we will make a Level Two internal appeal determination and call you within the lesser of 2 business days or 72 hours after receiving all information

needed for the review. Written notice of the Level Two internal appeal determination will also be provided within 2 business days.

The notice you receive will include detailed reasons for the Level Two internal appeal determination and, if a clinical matter is involved, the clinical rationale for the determination. The notice will also advise you of the right to apply for an external appeal, if the time frame for applying has not expired by the date of receipt of notice of an adverse determination on Level Two internal appeal.

(5) External Appeal

In general

You have the right to an "external appeal" of certain coverage determinations made by us or on our behalf. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by New York State; and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. In this section, "requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The time frames for expedited external appeals are shorter than the time frames for standard external appeals.

You may request an external appeal only if the requested service is covered under the contract.

(i) Coverage Determinations Subject To External Appeal

This subparagraph describes the general conditions for external appeal.

In general, you may not request an external appeal unless we have issued a "final adverse determination" with respect to your request for coverage after our Level One internal appeal. You may ask us to waive the Level One internal appeal; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination after a Level One internal appeal.

To be eligible for external appeal, the final adverse determination issued upon completion of our Level One internal appeal must be based on a determination that the requested service is not medically necessary or the requested service is experimental and/or investigational. You do not have the right to an

external appeal of any other determinations, even if those other determinations affect your coverage.

(ii) Conditions For External Appeal Of Determinations Of Medical Necessity

You may request an external appeal of a final adverse determination of medical necessity that is issued upon completion of Level One internal appeal, if you meet the conditions of this subparagraph and the general requirements of subparagraph (i). above. The provisions of this subparagraph apply only to external appeal of medical necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is or was not medically necessary.

(iii) Conditions For External Appeal Of Determinations Involving Experimental And/Or Investigational Treatment

This subparagraph governs the external appeal of determinations involving experimental and/or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials, which are governed by the section below.

To request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease, or a rare disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death; or that has lasted or can be expected to last for a continuous period of not less than 12 months; that renders you unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify that: standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or that no more beneficial standard treatment exists that is a covered service under the contract.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) that, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to

treat your life-threatening or disabling condition or disease. In the case of a rare disease, the attending physician must also certify that the requested health service or procedure is likely to benefit the insured in the treatment in the insured's rare disease and that such benefit outweighs the risks of such health service or procedure. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

If you meet the requirements of this subparagraph and all of the requirements of "Coverage Determinations Subject to External Appeal" above, you may request an external appeal. "Requesting an External Appeal" below provides information on requesting an external appeal.

(iv) External Appeal Of Determinations Involving Clinical Trials

This subparagraph governs the external appeal of determinations involving services provided in clinical trials.

To request an external appeal under this subparagraph, your attending physician must certify that you have a life–threatening or disabling condition or disease as described in "Conditions for External Appeal of Determinations Involving Experimental and/or Investigational Treatment" above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- The National Institutes of Health (NIH), and NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;

- An entity that has been identified by the NIH as a qualified non-governmental research entity; or

- An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of "Coverage Determinations Subject to External Appeal" above, you may request an external appeal. "Requesting an External Appeal" below provides information on requesting an external appeal.

(v) Effect Of The External Appeal Agent's Decision; Coverage

The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:

- For services denied as not medically necessary; we will treat the services as medically necessary and provide coverage subject to all other conditions of your coverage.

- For services denied as experimental and/or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of your coverage.

- For services denied as experimental and/or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under the contract. In addition, this external appeal right does not alter your cost-sharing responsibilities, if any, as otherwise provided for in the contract.

(vi) Requesting An External Appeal

If you meet the conditions described in this paragraph, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard external appeal request form to you when we have made a final adverse determination upon completion of Level One internal appeal. If your provider requested the Level One internal appeal of a retrospective adverse determination, we will send your provider a standard provider external appeal request form with the notice of final adverse determination. You or your physician may obtain additional standard request forms at any time by calling the New York State Insurance Department at 800-400-8882 or by accessing its website (www.ins.state.ny.us); by calling the New York Department of Health at 518-486-6074 or by accessing its website (www.health.state.ny.us), or by calling our Customer Service Department.

You must file your request for an external appeal with the New York State Insurance Department within 45 days of receiving a final adverse determination upon completion of Level One internal appeal; or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

A Level Two internal appeal is available to you as an alternative to external appeal (see "Level Two internal appeal" above); our Level Two internal appeal is optional. However, whether or not you request a Level Two internal appeal, your application for external appeal must be filed with the New York State Insurance Department within 45 days from your receipt of the notice of final adverse determination upon completion of Level one internal appeal, to be eligible for review by an external appeal agent.

You may be charged a fee of up to $50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

For a standard external appeal, the external appeal agent must make a final determination within 30 days of receipt of your request for review unless the agent requests additional information, which extends the agent's time to respond by an additional 5 days. For an expedited external appeal, the external review agent has 3 days to make a final determination.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the New York State Insurance Department, of the New York State Department of Health.

We urge you, but you are not required, to exhaust all levels of the applicable grievance procedure and/or utilization review procedure, before taking any further action with respect to our handling of your case. If you are not satisfied, you may contact the New York State Insurance Department at 800-342-3736 at any time during the review process. Upon request, the Customer Service Department will provide you with the appropriate address for writing to the Insurance Department.

C. WHEN COVERAGE ENDS

Coverage under the Plan terminates for a covered employee, retiree, and their dependents on the:

- Date the covered individual leaves employment
- Date the covered individual ceases to be in a class of participants eligible for coverage
- Date the participant fails to make any required contribution for coverage (for the contributory portion of the benefit)
- Date the Plan is terminated

Members will be provided with 90 days notice before termination of the Plan and 90 days notice before termination of a specific benefit.

When your coverage ends, the Plan will provide you with a certificate that documents your medical coverage for the previous 18 months. This certificate is required by the Health Insurance and Portability Accountability Act of 1996 (HIPAA).

D. CONTINUATION OF COVERAGE

There are certain situations in which the coverage for the employee and his or her dependents may be extended beyond the date in which it would normally end. These are:

1. In The Case Of A Disabled Child

Coverage may be extended beyond the age limit for a child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is chiefly dependent upon such member for support and maintenance. This is provided that the disability occurred before the age limit and the employee was enrolled in family coverage at the time of the disability. The employee must remain enrolled in the medical plan in order for the dependent coverage to continue.

2. Leave Without Pay

Employees who take a leave without pay may choose to continue their healthcare coverage. However, in certain situations, if an employee is granted leave without pay, the individual district may require that the employee pay the entire cost of the premium for the duration of the leave. Any employee who anticipates taking a leave without pay should consult with their local school district for further details.

3. Total Disability

If, on the day that coverage would have otherwise terminated, an employee or dependent is covered under the medical plan and is determined to be *totally disabled,* that individual may qualify for an extension of certain benefits. Benefits shall be provided during a period of total disability for hospital confinements commencing or surgery performed during the next 31 days for the injury, sickness or pregnancy causing the total disability.

Benefits will be extended with respect to the sickness, injury or pregnancy which caused the disability, of at least 12 months subsequent to termination of insurance unless coverage is afforded for the total disability under another group plan. *Total disability* is defined as any injury or illness that prevents an employee from doing a majority of the usual duties associated with the employee's occupation or, in the case of a dependent, any injury that prevents the dependent from participating in a majority of the usual activities of a person of similar age and sex.

4. Retiree Provisions

The provisions of the local individual school contract shall be subject to the following rules and limitations:

- If permitted in the local individual school contract, coverage may be continued for a retiree and his or her eligible dependents for life, or in the case of an eligible dependent until he or she is no longer an eligible dependent.
  - In the event a retiree continues to participate in the Plan and dies, his or her spouse may elect to continue the same coverage provided to the retiree at the time of the retiree's death for life;
  - In the event a retiree dies and his or her spouse elects to continue coverage in accordance with the preceding paragraph, in no event may such spouse apply for the coverage of his or her husband or wife upon remarriage;
  - In the event the spouse of a retiree dies and the retiree remarries, the retiree may apply to the Plan Sponsor for coverage of his or her new spouse, provided that:
    - The retiree continues to be covered under the Plan;
    - The application is made not later than 31 days after the marriage; and
    - The coverage for the new spouse is not greater that the coverage provided to the retiree.

5. As Required By COBRA

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was signed into law (Public Law 99-272, Title X). Under COBRA, most employers sponsoring group health plans must offer covered workers and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

If you are an employee covered by the Plan, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee or other worker covered by the Plan, you have a right to choose this continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

- The death of your spouse
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

In the case of a dependent child of an employee or other worker covered by the Plan, the child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

- The death of a parent
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- Parents' divorce or legal separation
- A parent becomes entitled to Medicare
- The dependent ceases to be a "dependent child" under the Plan

Under COBRA, the covered worker or a family member has the responsibility to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the Plan. Such notice must be made within 60 days of the event or the date on which coverage would be lost because of the event. The employer has the responsibility to notify the plan administrator of the covered worker's death, termination of employment or reduction in hours, or entitlement to Medicare.

Health care continuation rights also are available to covered retirees, their spouses, and widows or widowers of covered retirees, if they should lose group health coverage in the event that the employer should ever file for bankruptcy.

When the plan administrator is notified that one of the above named events has happened, the plan administrator will in turn notify you that you have the right to choose continuation coverage. Under the COBRA law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the plan administrator that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The COBRA law requires that you be afforded the opportunity to maintain continuation coverage for 36 months (i.e., 3 years) unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. *The 18-month period may be extended to 36 months if a second event (e.g., divorce, legal separation, death, or Medicare entitlement) occurs during that 18-month period.*

Note: If a qualifying event occurs less than 18 months after the date an employee becomes entitled to Medicare benefits, the coverage period for qualified beneficiaries other than the employee is extended to 36 months from the date of the employee's Medicare entitlement. Moreover, the 18-month period may be extended for an additional 11 months (for a total of 29 months) if an individual is determined to be disabled (under the rules for Social Security disability benefits) and the plan administrator is notified of that determination within 60 days. The affected individual also must notify the plan administrator when it is determined (for purposes of Social Security disability benefits) that the individual is no longer disabled.

The COBRA law provides that your continuation coverage may be cut short of the full coverage period – 18, 29, or 36 months – for any of the following reasons:

- the employer no longer provides group health coverage to any of its employees
- the premium for your continuation coverage is not paid
- you become covered under another group health plan that does not contain any provision restricting or limiting coverage of a "preexisting medical condition"
- you become entitled to Medicare
- there has been a final determination that you are no longer disabled, for beneficiaries who qualified for an extra 11 months continuation coverage based on their disability at termination or within the first 60 days.

You do not have to show that you are insurable to choose continuation coverage. However, under the COBRA law, you may have to pay all or part of the premium for your continuation coverage. Generally, for the 18 or 36 month continuation coverage period, you may be required to pay a maximum of 102% of the premium. If you are entitled to continuation coverage due to a disability, then for months 19 through 29, you may be required to pay 150% of the premium. *A minimum 30-day "grace period" will be allowed for you to pay your regularly scheduled premiums*. (COBRA also provides that at the end of the 18, 29, or 36 month continuation coverage period you must be allowed to enroll in an individual conversion health plan provided under the Plan).

6. New York Continuation Coverage

New York Insurance Law supplements COBRA requirements and allows an employee whose insurance ceases because of termination of employment or membership in the class or classes eligible for coverage under the policy to elect to continue the policy for up to a total of 36 months. For example, if you are eligible to continue health coverage under federal COBRA for 18 months, you can elect to continue coverage under state continuation coverage for an additional 18 months, and will be required to pay a maximum of 102% of the premium. If you are disabled under Title II or Title XVI of the Social Security Act and are eligible for state continuation overage, you are eligible for a

total of up to 36 months coverage and would pay a maximum of 102% of the premium for months 1-36.

Coverage under New York law may end sooner than 36 months due to the following reasons:

- Timely premium payment is not made to the Plan;
- The Plan sponsor ceases to maintain any group health plan;
- The employee or dependent is covered under any other group health plan not maintained by the Plan sponsor, even if such other coverage is less comprehensive than COBRA or New York continuation coverage; or
- The employee or dependent becomes entitled to Medicare benefits.

If you have any questions about COBRA or New York continuation coverage, or you or your spouse have changed address, please contact the plan administrator.

E. COORDINATION OF BENEFITS

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your medical treatment costs. If this is the case, benefits from the Plan will be "coordinated" with the benefits from the other plan so that the combined reimbursement does not exceed the Plan's normal benefit payment, up to any Plan maximums.

In addition to having your benefits coordinated with other group medical or dental plans, benefits from this Plan are coordinated with "no fault" automobile insurance (and any payments recoverable under any Workers' Compensation law, Occupational Disease law or similar legislation.)

1. How Coordination Of Benefits Works

When benefits are payable from more than one plan, the plan that pays benefits first is considered the "primary" plan. The plan that next pays is considered the "secondary" plan.

The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

When there is a basis for a claim under more than one plan, a plan with a coordination of benefits provision complying with this section is a secondary plan which has its benefits determined after those of the other plan, unless the other plan has a COB provision complying with this section in which event the order of benefit determination rules will apply.

The order of benefit payments is determined using the first of the following rules which applies:

(i) the benefits of a plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of a plan which covers the person as a dependent;

(ii) except as stated below, when a plan and another plan cover the same child as a dependent of different persons, called parents:

  (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

  (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

  (c) if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

  (d) the word birthday refers only to month and day in a calendar year, not the year in which the person was born.

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The aforementioned does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that person's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). However, if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the preceding sentence is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

- a change in the amount or scope of a plan's benefits;
- a change in the entity which pays, provides or administers the plan's benefits; or
- a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

F. ADMINISTRATION

1. Name Of Plan:

Chautauqua County School Districts' Medical Health Plan

2. Plan Year:

The Plan Year end is June 30th

3. Plan Sponsor And Plan Administrator:

The Plan is maintained by the Cooperative Members of the Chautauqua County School Districts' Medical Health Plan Cooperative

4. Employee Identification Number (EIN):

The EIN for this plan is 16-1278979

5. Plan Number:

The plan number for Medical Coverage is 001

The plan number for Prescription Coverage is 004

6. Type Of Plan:

The Plan is a Group Health Plan subject to Article 47 of the New York State Insurance Law

7. Type Of Administration:

The Plan is a municipal cooperative risk-sharing health benefits plan which obtains and maintains a certificate of authority from the New York State Superintendent of Insurance pursuant to the provisions of Article 47. Funds for payment of health claims are paid into a Cooperative from which claims are paid. All funds received by the Cooperative shall be applied toward payment of claims and reasonable expenses for administration of the Plan.

8. Agent for Service Of Legal Process:

The agent for service of legal process is Virginia C. McEldowney, Esq. at Damon Morey LLP, located at the Avant Building, 200 Delaware Avenue, Suite 1200, Buffalo, NY 14202-2150, Telephone: (716) 858-3885. The service of legal process may be made upon a plan cooperative member or the plan administrator.

9. Cooperative Members:

Cooperative Members are superintendents of the following school districts:

Bemus Point Central School
3980 Dutch Hollow Road
Bemus Point, NY 14712

Erie 2-Chautauqua-Cattaraugus BOCES
8685 Erie Road
Angola, NY 14006

Brocton Central Schools
138 West Main Street
Brocton, NY 14716

Cassadaga Valley Central Schools
P.O. Box 540, Route 60
Sinclairville, NY 14782

Chautauqua Lake Central Schools
100 North Erie Street
Mayville, NY 14757

Clymer Central Schools
P.O. Box 580, East Main Street
Clymer, NY 14724

Dunkirk City Schools
620 Marauder Drive
Dunkirk, NY 14048

Silver Creek Central Schools
P.O. Box 270
Silver Creek, NY 14136

Westfield Central Schools
203 East Main Street
Westfield, NY 14787

Forestville Central School
12 Water Street

Falconer Central Schools
2 East Avenue
Falconer, NY 14733

Fredonia Central Schools
East Main Street
Fredonia, NY 14063

Frewsburg Central Schools
26 Institute Street
Frewsburg, NY 14738

Jamestown Public Schools
201 East 4th Street
Jamestown, NY 14701

Panama Central Schools
41 North Street
Panama, NY 14767

Pine Valley Central School
7755 Rt. 83
South Dayton, NY 14138

Ripley Central Schools
P.O. Box 688, 12 North State Street
Ripley, NY 14775

Sherman Central Schools
P.O. Box 950, 127 Park Street
Sherman, NY 14781

Southwestern Central Schools
600 Hunt Road, W.E.
Jamestown, NY 14701

Forestville, NY 14062

10. Insurance:

Blue Cross/Blue Shield of Western New York provides claim payment services for medical benefits. Benefits are paid through contributions to the Cooperative.

Express Scripts, Inc. provides claims payment services for prescription drug coverage available through the prescription drug card plan. Benefits are paid through contributions to the Cooperative.

The Guardian Life Ins. Company provides claim payment services for dental benefits. Benefits are paid through contributions to the Cooperative.

Vision Service Plan provides claims payment services for vision care coverage. Benefits are paid through contributions to the Cooperative and Vision Service Plan has agreed to adjudicate claims.

The addresses of the organizations listed above are as follows:

Medical Plan Supervisor and
Prescription Plan Supervisor for Prescriptions under the Major Medical Plan
Blue Cross & Blue Shield of Western New York
257 Genesee Street
PO Box 80
Buffalo NY 14240-0080
1-800-888-0757

Prescription Plan Supervisor (*Except for Prescriptions covered under the Major Medical Plan)*
Express Scripts
One Express Scripts Way
St. Louis, MO 63121
1-800-332-5455

11. Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms and provisions of this plan or any provision of similar purpose of any other Plan, the Plan supervisor may, without the consent of, or giving notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person claiming benefits under the plan shall furnish the Plan Supervisor such information as may be necessary to implement this provision.

Whenever payments which should have been made under this plan in accordance with the above provision have been made under any other plans, the Plan Supervisor will have the right to pay to any organizations making these payments any amount it determines to be warranted in order to satisfy the intent of the above provisions, and amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan Supervisor and the Plan Sponsor will be fully discharged from liability under this Plan.

12. Reimbursement Provision

If a covered member is injured through the act or omission of another person, the benefits of this plan shall be provided only if the employee shall agree in writing:

- To reimburse the Plan to the extent of the benefits provided, immediately upon collection of damages by him/her, whether by legal action, settlement, or otherwise, and
- To provide the Plan with a lien and order directing reimbursement of medical payments, to the extent of benefits provided by the Plan. The lien and order may be filed with the person whose act caused the injuries, his agent or carrier, the court, or the attorney of the employee.

A representative of the Plan shall have the right to intervene in any suit or other proceeding to protect the reimbursement right hereunder. The covered individual shall be responsible for all fees of the attorney handling the claim against the third party.

13. Right of Recovery

Whenever payments have been made by the Plan Supervisor with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan Supervisor shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan supervisor shall determine:

- Any person, to, or for, or with respect to whom such payments are made:
- Any insurance company; and

- Any other organization of the type which provides services, or pays any benefits of the kind defined within this plan.

14. Subrogation

If any expenses covered under this Plan arise from acts or omissions for which a third party may be legally liable, and if such third party fails or refuses to make prompt payment of such damages, then the Plan may pay for such benefits or services as are provided herein, and the Plan thereupon may be subrogated to any claims which any covered person may have against such third party causing the covered expense to the extent of such payment. However, except where there is a statutory right of reimbursement, no party (either the potentially liable third party or the plan participant) shall be required to reimburse the Plan with respect to losses following a settlement in an action for personal injuries, medical, dental, podiatric malpractice, or wrongful death.

G. COMPLIANCE WITH APPLICABLE FEDERAL LAWS.

In addition to complying with COBRA and HIPAA as described in this Summary Plan Description, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as the Uniformed Services Employment and Reemployment Act of 1994 (USERRA), Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Women's Health and Cancer Rights Act of 1998 (WHCRA), Mental Health Parity Acts of 1996 and 2008, and Family Leave Medical Act of 1993 (FMLA).

H. COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. PLAN'S DESIGNATION OF PERSON/ENTITY TO ACT ON ITS BEHALF

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Health Plan Committee to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule *(e.g.,* entering into business associate contracts; accepting certification from the Plan Sponsor).

2. DEFINITIONS

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

a. Plan means the Chautauqua County School Districts' Medical Health Plan.

b. Plan Documents mean the Plan's governing documents and instruments *(i.e.,* the documents under which the Plan was established and is maintained), including but not limited to the Chautauqua County School Districts' Health Plan Document.

c. Plan Sponsor means "Plan Sponsor" as defined at Section 3(16)(B) of ERISA, 29 U. S.C. § 1002(16)(B). The Plan Sponsor is Cooperative Members of the Chautauqua County School Districts' Medical Health Plan Cooperative.

3. **Plan's Disclosure of Protected Health Information to Plan Sponsor - Required Certification of Compliance by Plan Sponsor**

a. Except as provided below with respect to the Plan's disclosure of summary health information or enrollment/disenrollment information, the Plan will disclose Protected Health Information to the Plan Sponsor only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

- the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with 45 CFR § 164.504(f);

- the Plan Documents have been amended to incorporate the Plan provisions set forth in this Amendment; and

- the Plan Sponsor agrees to comply with the Plan provisions as modified by this Amendment.

4. **Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor**

a. The Plan (and any business associate acting on behalf of the Plan), will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Amendment.

b. All disclosures of Protected Health Information by the Plan's business associate(s), to the Plan Sponsor will comply with the restrictions and requirements set forth in this Amendment and in the HIPAA Privacy Rule.

c. The Plan (and any business associate acting on behalf of the Plan), may not disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

d. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the HIPAA Privacy Rule.

e. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received

from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

f. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

g. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the HIPAA Privacy Rule, of which the Plan Sponsor becomes aware.

5. **Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor.**

a. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

b. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

c. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

d. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

e. The Plan Sponsor will ensure that the required adequate separation, described in paragraph VII below, is established and maintained.

6. **Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

a. The Plan may disclose summary health information to the Plan Sponsor without a signed certification from the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

- Modifying, amending, or terminating the Plan.

b. The Plan may disclose enrollment and disenrollment information to the Plan Sponsor without a signed certification from the Plan Sponsor.

7. **Required Separation between the Plan and the Plan Sponsor**

a. In accordance with 45 CFR §164.504(f), this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan.

- Privacy Officers of each participating school district
- Supervisors/Business Managers
- Human Resources/Employee Benefits Personnel
- Clerical Personnel
- Information Technology Personnel

b. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they may be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

c. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and reduce the harmful effect of the violation or noncompliance.

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CHAUTAUQUA COUNTY SCHOOL DISTRICTS'
MEDICAL HEALTH PLAN

CONTRACEPTIVE DRUGS AND DEVICES RIDER

This is a Rider to your Medical Health Plan ("Plan"). This Rider covers contraceptive drugs or devices approved by the Federal Food and Drug Administration which are prescribed by a licensed health care provider legally authorized to prescribe under Title 8 of the Education Law. Coverage is not provided for over-the-counter contraceptive drugs or devices.

The copayment for oral contraceptives and injectables contraceptive drugs and devices shall be determined in accordance with the prescription drug plan that applies to the participant. Under the Major Medical option, prescription drugs are covered at 80%, subject to the annual deductible and out-of-pocket maximum as described in the Summary of Medical Benefits Section. Under the Prescription Drug Card Plan, the coverage depends on the option that applies to the participant as determined by their individual school district.

Coverage under this Rider is subject to all the exclusions in your Plan. All of the terms, conditions, and limitations of the Plan to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.